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A Foster Grandparent Program

Conflicts in Behavioral Research

Home Therapy for the Retarded

Youth Services in England

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Reaching out for each other's love, this foster grandchild and her foster grandmother meet every day to help each other, each in her own way. Through the program described in our lead article, older men and women and neglected, disturbed young children are brought together as foster grandparents and foster children to the good of both. (See page 46.)

children

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They wait at the gate to greet their foster grandparents. Eager, impatient children wait for equally eager foster grandparents who will take them out of the group-care unit of the county child welfare agency to the privacy of a vacant sitting room, office, niche in the hall, or spot under a shade tree on the institution's grounds.

All are children being cared for by the Medical and Emotional Treatment Service Unit of the Summit County (Ohio) Child Welfare Board, known by the staff as the METS. Most of them are of preschool age, and most of them have physical, mental, or emotional handicaps, or a combination of these problems. All are under the county's care as dependent and neglected children.

The foster grandparents come to the children for 4 hours a day through the Foster Grandparents Project, a demonstration project to give employment to needy persons who are over the age of 60, sponsored by the Office of Economic Opportunity (OEO) and the Administration on Aging of the U.S. Department of Health, Education, and Welfare. The chief interest of the Summit County Child Welfare Board in participating in the project, however, has been in tapping the potential of foster grandparents as treatment agents in its social casework efforts to help the children to a happier life.

Through its METS unit, the Summit County Child Welfare Board provides temporary group care for some young children who must be removed from their homes for their protection—and sometimes their very survival—and for whom no other arrangement is immediately available. Many children arrive at the agency with such aggravated behavioral problems that even the most experienced and capable foster parents could not cope with them. Even some very young children seem so damaged by their experiences that they need the kinds of control that can be provided only in group living before they can form the kinds of relationships with other human beings that are prerequisite to a successful foster home experience.

Like most child-care agencies, however, our agency has realized that its child-care workers could not give individual children enough attention to provide them with the necessary ego-building experiences. Such children, we felt, needed the kind of loving, personal attention that a foster grandparent might be able to give them.

Our agency was one of the first 21 agencies chosen by the Administration on Aging to participate in the Foster Grandparents Project. Planning took

some casework aspects of using . . .

FOSTER GRANDPARENTS FOR . . . . . emotionally disturbed children

RUTH JOHNSTON

place in 1965. It was agreed then that each participating agency would adapt its program to the needs of the children under its care within the framework of policies established by the Administration on Aging and OEO. The agencies would choose the grandparents, train them for their work, and assign them to specific children.

The staff for the Summit County Foster Grandparents Project consists of a part-time director from the agency's social service staff, a part-time supervisor hired especially for this position, and a part-time consultant and a full-time field supervisor from the agency's institutional child-care staff. In addition, a five-member advisory committee, representing senior citizens groups, labor unions, the Summit County Child Welfare Board, and the local community action council, meets together regularly to review the program's policies.

Selection and orientation

The actual hiring of grandparents began in January 1966. Ten grandparents were accepted at that time from 75 applicants. Later, the agency employed two other groups of foster grandparents—10 in each group. Of the 30 foster grandparents employed, 23 are still in the project—18 grandmothers and 5 grandfathers.

For acceptance to the program, the applicants had to meet the OEO criteria of having no more than $1,800 per year income (since lowered to $1,500) and of being over 60 years of age. They also had to have their physician's approval and had to be able to hear and see well, to move around easily, to pick up small children, to climb stairs, to sit on the floor, and to play games.

Other criteria called for the subjective judgments of agency staff members made on the basis of personal interviews and of study of the foster grandparents' written applications: functional literacy; reasonably good grooming; pleasant appearance; ability to listen and ability to express meaning; and some indication of having had enjoyable experiences with children, their own or other people's.

In our selection process, we sought evidence of satisfactory life experiences; adequate adjustment to age and financial status; an interest in people, especially children; a wish to be of service to someone; and an ability to understand and accept the agency's policies. We tried to find clues to these qualities during the application process and through observation of the applicants as they were shown through the METS unit. One crucial test was the "touch test"—a literal reaching out to children followed by a spontaneous and positive response from the children.

Before the orientation program began, we had wondered whether older people not used to an academic approach would be able to accept and benefit from an orientation program. We had wondered how approachable they would be in respect to the staff

and one another and how adaptable they would be to the routine and policies of the agency. We were pleasantly surprised to find that the foster grandparents immediately saw themselves as a "group" and began at once to participate in the discussions. They seemed to have the wisdom that comes with age and genuine interest in the project.

The orientation began with an overall description of the agency, its plant, staff plan, and major policies regarding child care. But, the chief focus was on helping the foster grandparents understand the children and how to work with them. When we outlined the ways in which children normally develop, we found the foster grandparents were interested from two standpoints: (1) As a new way of looking at child-rearing practices, since most of them had never before considered child rearing from a theoretical point of view; and (2) as an opportunity to tell of their experiences with their own children and grandchildren.

After discussing theory, we focused our attention on the particular children with whom the grandparents would be working. Again we were pleasantly surprised at the general openmindedness and flexibility shown in these discussions. However, we found out later that all the foster grandparents had not understood all of what was said and were not actually prepared for the situations they would face. But, in spite of some difficulties with the children, they stood pat in their determination to help the children assigned to them.

We tried to help the foster grandparents understand that these children would not be like their own grandchildren and that as foster grandparents they would have different obligations and responsibilities than as grandparents. We told them that a major goal of the project was to meet each child's needs and help him solve his problems.

During the orientation week, we discerned many kinds of strength in the foster grandparents—sincerity, security, self-esteem, flexibility, warmth, and stamina—that we hoped would be passed on to our children. We also found weaknesses in these areas. However, by appraising each individual, we attempted to match grandparent and child so that their strengths and weaknesses would complement one another's. The goal was to provide the child with a person to whom he could relate and in whom he would see the qualities he needed most.

By the end of the orientation week, everybody was eagerly anticipating the climax—the assignment of particular children to particular grandparents. We arrived at these assignments on the basis of information received from the agency's child-care workers and the children's social workers. While these workers were usually in general agreement about the child's needs, the child-care workers tended to emphasize behavioral problems and the social workers to emphasize inner conflicts. Where it seemed necessary, we had conferences with the workers on particular children before coming to a decision. In all assignments, the child's needs were given first priority. No consideration was given to race or age of grandparents or child.

Agency team members

The first foster grandparents received their assignments on January 28, 1966. On that day, the foster grandparents, all of whom had been introduced to all the children previously, were literally sitting on the edge of their chairs in their eagerness to find out which ones they would get. Without exception they accepted the children selected for them. Subsequently, either the director or supervisor talked with the grandparent, giving him information about his particular child that would help him in working with the child. The grandparent was frankly told about the child's present problems and what the agency's long-term goal for him was, given suggestions for dealing with the child, and encouraged to do "what comes naturally" within the framework of the agency's rules and the child's special needs.

Each foster grandparent and child were assigned a place where they could be alone together and were supplied with a bag full of toys selected for that particular child and used by him only when he was with his foster grandparent.

The foster grandparents showed a surprising ability to understand and accept the basic policies of the agency with regard to the development of children and to help us implement them. In fact,

Ruth Johnston has been since 1965 administrative supervisor, Summit County (Ohio) Child Welfare Board, where she is also director of the Foster Grandparents Project described here. Previously she was for 13 years director of child welfare in the Arkansas Department of Public Welfare. A graduate of the Columbia University School of Social Work, she has also worked in child welfare in North Carolina.

one of our staff members has used the term "intuitive casework" to describe what some of the foster grandparents have done.

We feel, and let the grandparents know we do, that they are a part of an agency team caring for children. They keep a record of their work with the children and are encouraged to report both the good days and bad days and to express their own thoughts about the child, his problems, and his progress. These records are shared with the child-care and social work staffs. The entire staff has been pleased to see how pertinent they are.

Warm relationships between the foster grandparents and their assigned children began developing immediately, and the grandparents soon learned at first hand about the children's problems.

One grandmother wrote after a short time:

Johnny was so glad to see me. They told me he could hardly wait until I came. We got our toys and went to our room. I noticed he was nervous and shy. All at once he began to open up to me and tell me how his mommy had come and brought him some toys, and he asked me to please help him grow up so he could whip his daddy for beating up his mommy. It broke my heart to see him in this attitude. I think parents' troubles shouldn't be pushed on the child, especially at this age. Johnny is very smart and understands more than most children his age.

This grandmother has said that Johnny's show of feeling came as a shock to her even though she had been warned. However, a warm relationship has developed between them.

In this early period a foster grandfather wrote of a very disturbed little boy:

He is to me the greatest because he is my grandson. He is not what I would call a bad, bad boy. Sometimes he is nice as he can be, otherwise is real mean, but I hope to help to make a good boy out of him. There are times I think I see a big change. I hope every day I can find some way to cope with him.

The grandfather has found a way to cope, and the change in the child is almost unbelievable.

One woman was assigned a little girl who was so withdrawn that she went for days without speaking. After a while this foster grandmother wrote:

I have noticed a change in her personal pride. Now she will ask me to comb her hair, give her a bath, put her in a dress instead of pants. These are things she did not even notice when I got her, and to me this is a marked improvement, for as long as you can keep a child's personal pride up and keep it feeling someone else cares you have a chance of their trying to build a life.

In general, the foster grandparents have been most willing to share their impressions with other staff members. However, as they get to know a child they tend to become increasingly protective of him and have to be reminded from time to time that their job is not to protect the child from criticism, but to work with everyone else toward helping him overcome his problems.

Some foster grandparents have been remarkably acute in their observations. One recorded:

Every day I understand him better and treat him as an individual. He seems to be searching for something he can't quite find, and to be inwardly at war with himself, which makes him resentful and rebellious.

Some byproducts

After nearly a year we are able to appreciate the program from the standpoint of the agency, the social work staff, the child-care staff, the foster grandparents, and of course the children.

Agency benefits. In addition to what the program has done for our children, it has resulted in increased community good will toward the agency. The 30 foster grandparents and 5 advisory committee members who have taken the orientation course and the community agencies that have referred prospective foster grandparents to the agency now have a better understanding of the agency and its program. And the agency has been called to the attention of the public at large through favorable news and magazine stories focused on the opportunity it has given older people to work with children.

Casework benefits. The agency's social workers probably had both the greatest hope and the most misgivings of all the staff members about the Foster Grandparents Project. They realized that the children would benefit from a one-to-one relationship that the child-care workers could not provide. They recognized that one or two visits a week from a caseworker was not enough to sustain a very young, disturbed child. However, their training and experience had taught them the value of skilled casework based on investigation, diagnosis and treatment, and they wondered how foster grandparents with no professional education could fit into a casework plan.

The social workers also wondered how, with the restrictions on age and income set by the Office of Economic Opportunity, foster grandparents could be found who were not too physically, culturally, and educationally limited to be able to give the children what they needed. They also wondered whether the children would be faced with conflicts in loyalty between caseworkers and foster grandparents or be-

tween foster grandparents and the child's own parents and relatives. They wondered whether the foster grandparents would have enough understanding and stamina to bear up under the child's expressions of hostility or whether they would get enough satisfaction out of the job themselves to be able to give anything of value to the child.

Almost without exception, the social workers' fears have been laid to rest and their hopes fulfilled. Moreover, they have often found information gained from the grandparents useful in furthering their own understanding of the children in their caseloads. For example, a grandparent wrote of a child:

We went for a walk today and she opened up a bit by talking of her mother, whom she mentions quite often, but more than her mother she speaks of her father. Sally asked me why doesn't her daddy get well. I did not know what or how to answer her but I tried to make her feel better. . . .

Sally had not previously revealed her deep concern about her father. Learning of it through the foster grandparent, the social worker could help the little girl deal with it.

During the past year, among the children who were assigned foster grandparents, nine have been returned to their own homes and nine have been placed in foster family homes. While the foster grandparents cannot be given the entire credit for the emotional progress that enabled these children to go into a family setting, in each case a foster grandparent made a definite contribution toward it. The social workers helped the child use the relationship with his foster grandparent to find the strength for these moves.

While the grandparents have felt sad at the loss of the children, in each case they gave them real support in moving on. One foster grandmother wrote to a once extremely withdrawn child:

This is from your dear grandmama, and I must say that I have enjoyed you so very much since I have had you in my care, and I did my best to bring you up to here with a secret prayer. Wherever you go, or wherever you be, I pray that the good Lord will be there.

Another foster grandmother who had helped a very aggressive child establish control recorded:

Bill has been informed he is going to a foster home where he will have a mommy and daddy. He is strong willed sometimes, slow to obey, but, if let alone, he will change his attitude. I am very happy that he has a mother and daddy plus a good home because that is what every child needs to develop a strong character and become a good citizen. I really am reluctant to give him up, but it is for a better way to develop finer character. I keep telling him he is leaving his foster grandmother for a real foster mother plus a home of his own and so much else to make him feel free and happy.

Some of the social workers have reported that the children in their caseloads are more approachable since they have had foster grandparents, that they talk more to the social workers, listen better, are more able to bear the separation from their parents, and generally have a better feeling about people, particularly the adults in their lives. One grandparent wrote a little boy who 3 months earlier had had great difficulties in personal relationships:

It has been a pleasure working with Dan, also a real challenge at times, but it has been rewarding just to see him grow in size, disposition, and temperament. He has changed from the sulky, disobedient little fellow I met on May 3. I feel my time and effort have been well spent.

Child-care benefits. The foster grandparent program has meant that some children are out of the child-care unit for 4 hours a day, thus giving the child-care workers more time to spend with the children who do not have foster grandparents. As a result, the children in group care are happier, more relaxed, and more controllable.

The houseparents tell us that having a foster grandparent is a "status symbol" among the children. They also report that the children who have foster grandparents play better, eat better, sleep better, and look better than the other children.

Children in METS who do not have grandparents are those who are in temporary care, who are too young, or whose particular needs could not be met by any foster grandparent who is available for assignment at the time.

Some minor difficulties have occurred in the METS unit since the initiation of the foster grandparent program. Child-care workers and foster grandparents sometimes meet head on with conflicting ideas, often involving housekeeping problems, and occasionally resulting in bruised feelings. However, since foster grandparents and child-care staff alike have genuine concern for the welfare of the children, none of these minor difficulties have amounted to anything that poses any real problem. There is generally a friendly, satisfying give and take between foster grandparent and houseparent. If any real difficulty should arise between them, however, the supervisor of the child-care staff would be responsible for dealing with it.

Grandparent benefits. The foster grandparents themselves all seem to enjoy a feeling of being of use. One foster grandfather said recently that it gives him a reason for getting up in the morning.

When the foster grandparents are asked what the experience has meant to them, they nearly always

cite the progress they see in the development of the children assigned to them and their pride in their accomplishments. One grandparent reported:

Fred was very good and played good and was in an unusual good mood all morning. He did not bite or try to bite me or anyone.

In spite of being bit, hit, kicked, spit on, cursed, run away from, berated, yelled at, and disobeyed, the foster grandparents have kept perspective and have often seen the deeper meaning of the child's behavior and even the humor in it. One seriously disturbed child suddenly hit his grandmother with a knife handle and then complained because she bled. Three months later the same child accidentally kicked the grandmother while playing and was most solicitous and concerned. The foster grandmother reported both incidents, the second with pride, even though it had resulted in a black eye for her.

There has been almost no absenteeism among the foster grandparents except for illness. They have come to the agency through cold and heat and on holidays. They have gone with their children on all-day picnics, hikes in the woods, walks in the park, visits to the circus; they have gone wading with them to help them catch tadpoles; in short they have gone wherever the children have gone, without question and apparently with pleasure.

The children

The *raison d'être* of our program is, of course, the children—what they have needed, what they have received, and what they have become. For them the experience has been a positive one physically, mentally, and emotionally. We have followed Erikson's eight stages of man [1] in classifying the development that has taken place in the children during this period. Some children have made remarkable progress; others, very little. However, in every case some progress is evident.

Sense of trust. For many of our children the relationship with their foster grandparent is the first positive relationship they have had with an adult. It starts, whether the child is age 2 or 8, with having a lap to sit on and involves being cuddled and comforted. It moves on to confidence that the foster grandparent will do what he says he will do.

Before coming to us many of our children have been given little in their own homes except the bare essentials. Yet after a child's placement away from home, his parents often try to make up for their own hurt and that of the child by bringing him gifts. To the child these seem only a superficial token of love. We try to restore the proper balance by having the foster grandparents give the children much attention and warmth but little in a material way. The foster grandparent and the child take a walk together to enjoy one another and the outdoors rather than to get an ice cream cone. However, if occasionally the grandparent combines the two purposes, we do not object.

The attention this foster grandparent is giving a sick-abed child is clearly making this little girl forget her illness.

Autonomy. Through their genuine feeling for the children, the foster grandparents have helped absolve some of the shame and doubt brought on the children by the loss of their parents.

We believe that the grandparents, using their own experience, interest, initiative, and imagination, have helped develop the children's personalities in a more personal and intimate way than could have been done by a social worker or child-care worker. They have helped children develop a feeling of worth by offering them warm affection, and this affection has deepened as the children have begun to return it. They have demonstrated their sense of the child's worth by doing things for him—bathing, dressing, combing hair, tying shoes, pulling up socks, putting on mittens and cap. Through words, expressions, and gestures, they have shown appreciation of the child himself and their pleasure in the way he looks, behaves, and

achieves. With very young children, they have done this unconsciously through simple games such as "Show me your nose."

The fact that the foster grandparent "belongs" to the child adds to the child's sense of worth. Children have shown their need and their appreciation of this by being very possessive of their grandparents and very jealous of their attention.

Initiative. The grandparent not only encourages the use of the creative toys provided for the child; he also participates in imaginative play with them, thus helping the child learn to use initiative and imagination. Showing his appreciation of the child's creative efforts, he encourages the child to experiment not only with what he can do with his own mind and body but also with how he can control outside things.

Many of our children have insufficient ability to express themselves in words. Not having been encouraged to talk in their own homes, they tend to act out rather than talk out their feelings. Because of this we have urged the foster grandparents to read aloud to the children, to tell them stories, and above all to talk to them and to encourage them to respond. As a result, many of the children have learned to talk not only about the things they see around them but also about their thoughts and feelings.

Industry. We have encouraged the foster grandparents not only to do things for the children but also to expect the children to do things for them and eventually for other adults and other children. Children willingly run errands for grandparents, help them pick up toys, and do other things because "Grandmother asks you to," and they seem to derive a sense of satisfaction from it.

Foster grandparents have also taught children how to greet people, how to eat properly, and how to take care of themselves and their clothing. Many of our children have had no previous opportunity to learn about such social amenities. Feeling comfortable in these areas increases the child's self-assurance, thus releasing energy for further growth.

Foster grandparents have also helped some children prepare to enter school. By showing their appreciation of the children's efforts they have made learning easier for the children.

One determined foster grandparent helped a physically handicapped little girl who had spent most of her time in a wheelchair progress first to a walker and then to crutches. There were numerous clashes of will, sometimes ending in a draw, but most often in the grandparent's maintaining control and in turning the experience into a positive one for the child.

Sense of identity. The foster grandparents have helped children establish a sense of identity by each transmitting to his child his feeling that the child is special, through helping him know what he can do, and through helping him accept controls. Many of our children before coming to us were controlled too harshly or not at all. The foster grandpartents are making a great contribution in helping the children respect both their own rights and the rights of others by establishing a benign control.

The foster grandparents have also helped children learn to share—for example, to take turns on a tricycle. The grandparent is obviously proud when his particular child awaits his turn, especially when the child thinks of something interesting to do while waiting.

The grandparents have also helped the children become conscious of the world around them. We have encouraged them to take their children walking and to call attention to the sunlight, fresh air, green grass, birds, insects, and pebbles. Last spring METS was ablaze with dandelions in peanut butter glasses. Last summer it housed large collections of tadpoles, bugs, and pebbles. Last fall, red and yellow leaves lined the walls.

We believe that the very fact of being taken out of the group physically for a period of quiet and relaxation with only one other person has been of great benefit to the child. It has not only allowed him the satisfaction of a one-to-one relationship but has also given him an opportunity to become acquainted with himself and to learn about his own areas of strength and limitation by experimenting on an accepting adult.

Obviously, we feel that this experiment has been a success.

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[1] Erikson, Erik H.: Childhood and society. W. W. Norton & Co., New York. 1950.

a research psychologist discusses some . . . . . .

CONFLICTING VALUES AFFECTING **BEHAVIORAL RESEARCH WITH CHILDREN**

M. BREWSTER SMITH

What limits, if any, should be set on research into children's behavior? Who should set these limits? These, and other questions related to them, are being asked these days by many people in and out of research—parents and lawmakers included.

Only recently, when research on behavior was a marginal activity of a few college professors and their graduate students, carried out with little financial support and that support received mainly from private donors and foundations, such questions hardly arose. From the professor's standpoint, the responsibility for decisions about the nature of the research was solely his—a matter of academic freedom and privilege within the framework of formal or informal codes of professional ethics. Nobody was likely to challenge him: The whole enterprise of research in the behavioral sciences was unimportant and inconspicuous, and public funds were not involved.

Today, however, the behavioral scientist has to pay the penalty for success. Behavioral research is no longer inconspicuous: Even though it is not as affluent as the physical sciences, it is now big business. And since most of its financial support now comes from the Federal Government, its errors of judgment as well as its successful results now attract political attention. Public concern with the methods that scientists use in studying other people is of course warranted on grounds quite apart from the basis of funding.

For perspective on the special problems of controls on research with children, we had best begin with a brief look at the anxieties and misgivings about the political and ethical aspects of the behavioral sciences that figure prominently in the current climate of discussion.

Many people, including U.S. Congressmen, are worried about many loosely related issues. Do personality questionnaires violate the citizen's right to privacy when used in government personnel procedures or in research?[1] Is it ever permissible for experimenters to deceive the subjects of their experiments, as some types of investigation seem to require?[2] If deception is used, how can the "informed consent" of subjects be obtained?[3] Do the potentialities for computer retrieval of data collected for administrative purposes (tax returns, census files, and the like) threaten the privacy and perhaps even the liberty of the individual citizen? What of Government-sponsored research in foreign countries—how can the sensitivities of the citizens of other countries, the interests of the U.S. Government, and the needs of the social sciences for comparative data all be taken into account?[4] How can the Government and the public be assured they are getting their money's worth out of social and behavioral science? Is adequate support available for the study of socially important

problems?[5] All these questions and many others have found their way into the legislative hopper. Several congressional committees have held hearings that bear upon them. Suddenly, the social and behavioral sciences are politically visible.

Issues concerning children

Each of these issues has its counterpart for research on the behavior of children, though issues concerned with studies of children in foreign countries have not yet received much attention. But the issues look and are different when children are involved.

Personality questionnaires and the right to privacy. When children are questioned for research purposes, the privacy and sensitivity of parents have to be considered in addition to the possible effects of the questioning on the child. Some kinds of questions—those about sexual attitudes, knowledge, and practices, for example—are likely to be regarded as intrinsically inappropriate in questionnaires for use with children; questions about child-rearing practices, on the other hand, may be seen as invading the parents' right to privacy and perhaps even as undermining parent-child relations.

Parents who have little understanding of the methods or objectives or value of behavioral research have objected to their children's being asked about their parents' education and other indicators of socioeconomic status—seemingly incidental information that is often essential in a research project! Very likely only a few parents would be disturbed by the kinds of questions a responsible investigator would find necessary and proper to ask, but their objections have to be taken seriously, not dismissed impatiently as "crackpot." The narrowest interpretation of what is permissible would put many important problems beyond the range of possible research. The most lenient would affront many citizens.

Deception. In this regard, the issues concerning children shape up differently from those concerning deception with college students and adults. In a typical case, the problem under study requires the subjects to undergo a standard sequence of successes and failures on an experimental task. To produce this standard sequence, the subjects are provided with believable false reports about their performances of the task, according to the requirements of the experimental design.

Generally, investigators working with adults or college students attempt to meet the ethical problem in such deception by carefully explaining the reason for the deception to each subject after the experiment is over. When the subjects are students in psychology courses, such a "debriefing" procedure usually makes sense (though it may not balance the harm done to the students by conveying the idea that a manipulative approach to people is acceptable). When "debriefing" is carried out scrupulously, the participant may learn something relevant to his studies, both about psychological research and about his own reactions.

In research with young children, however, no one can argue for "debriefing" as an adequate solution to the ethical problem of deception. A full explanation of procedures to the young child is seldom desirable or possible. In the example that we have been considering, the usual scrupulous practice would be to so contrive matters that by the end of the session every child would leave with a solid experience of success.

Yet such a solution leaves one uneasy. The experimenter who knows that he must subsequently explain to his adult subjects just how he has deceived them may be likely to exercise self-restraint in his procedures. The experimenter with children is under no obligation to explain himself to his subjects, and if he is not required to justify his procedures to others, everything hinges on his private judgment. Can the experimenter's unavoidably self-interested judgment of what is best for the child be trusted?

Consent. The difficult but crucial issue of when the participant in research may be regarded as having given his informed consent appears in a different guise in respect to research with children. Legally, only parents can consent on behalf of children. But when is parental consent "informed"? How much do parents have to know about a particular research project before their consent may be so regarded? When, if at all, may the responsible authorities in schools and other social agencies give consent *in loco parentis*? When, if at all, may implicit consent be assumed? Any call for a rigid enforcement of a requirement for explicit parental consent presents serious obstacles to research studies that hinge on obtaining data from a representative sample of children. This is because, in ways that affect their children, the parents who neglect to return consent forms may differ from those who do return them. A narrow interpretation of the consent issue could very seriously hamper behavioral research with children.

Uses of information. Whether information col-

lected for administrative purposes that can be retrieved and collated by a high-speed computer for other purposes presents risks to the privacy and liberty of adults is still a matter for conjecture, since such data banks are not yet generally available. However, the cumulative school records of children's psychological tests are already with us and may do real harm.

Useful as ability tests undoubtedly are, they are clearly a mixed blessing.[6, 7] The low test scores of a child who gets off to a poor start may exclude him from opportunities to improve his position. Teachers who rely on the predictive power of a poor score help confirm the prediction. On the other hand, without test results, social stereotyping might play a larger part than it does in deciding a child's educational future. Much careful thought and further research are needed to find ways of using ability tests so as to maximize each child's educational opportunities instead of accentuating existing inequalities of opportunity. Because the testing technology is a product of scientific psychology, problems concerned with the administrative use of tests naturally get entangled with the logically distinct problems of their research uses. It is important to keep the issues separate.

Information collected from children for research should never be used to their disadvantage. When the nature of the research permits data to be collected and stored anonymously, the interests of the individual child can be readily protected. When, on the other hand, identification of individual persons is essential to the research—as in "longitudinal" studies that follow the same persons over a period of time—elaborate precautions are essential to safeguard confidentiality. In such research, protecting the anonymity of the persons studied is an absolute about which there can be no compromise.

Competing values

As we explore these issues, it is easy to become preoccupied with the dangers of using children as subjects of behavioral research and the safeguards necessary to protect them at the expense of appreciating the actual and potential contributions of behavioral research to child welfare. The cumulative findings of research on child development are just beginning to break the cyclical fashions in child-rearing advice.[8] In this country we are just launching a host of new and expensive programs in the schools based on extrapolations from current knowledge about behavior that urgently require monitoring and rigorous evaluation through research. Now is not the time to stifle behavioral research with severe restrictions.

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In its own interest, the public needs to make some accommodations to the requirements of research. Behavioral scientists and the agencies that support their work should be actively involved in educating the public and its representatives in Government to the characteristics and value of such research.

The beginning of wisdom in this regard, it seems to me, is to recognize that we must come to terms with competing values. Humanitarian values require that we never harm the individual child and always strive to advance child welfare. Libertarian values require us to respect the integrity and privacy of the child and his parents. Scientific values prescribe the extension of knowledge for its own sake, usually with the faith that in the long run knowledge contributes to humanitarian ends. Legal values require us to respect the status of minors and the rights and obligations of parents, though legal rights in relation to behavioral research are still in the process of clarification.[3] Often these different frames of evaluation point to the same conclusion. The cases in which they do are the simple ones that pose no serious practical or ethical problem. But often they conflict with one another. For example, the child's privacy and perhaps his integrity are violated for the sake of advancing knowledge of a topic that is theoretically and humanly important when, in a study of how moral character develops, he is tempted to cheat and whether he does so or not is surreptitiously observed. In such instances, we need principles and mechanisms for adjudication.

Both principles and mechanisms become indispensable once we grant that decision on these conflicts in values can no longer be left to the unaided conscience of the individual investigator. Now that behavioral science has grown so important that it captures pub-

lic attention, forces are clearly such that decision will not be left to the individual investigator. Nor should it be. He is likely to be a biased judge, one who will set a higher priority on scientific values than nonscientists are likely to do. He wants so much to conduct research and to advance knowledge that, being human, he may underestimate or rationalize away the costs and risks to his subjects. At any rate, he is open to the legitimate suspicion of being vulnerable to bias. Anyone who has been privy to discussions among tough-minded behavioral scientists about the "trade off" between ethical risks and potential scientific gain will have no doubt that this bias exists.

Codes of ethics

Further codification of ethical principles by the scientific disciplines concerned to help guide decision in the difficult cases is a much needed first step. Existing codes of ethics provide a good start but they stop short of some of the harder issues before us. Thus, the code adopted in 1959 by the American Psychological Association [9] provides for the confidentiality of research materials and calls upon the psychologist to show "sensible regard for the social codes and moral expectations of the community in which he works. . . ." In what is probably the critical principle, it states:

> **Only when a problem is significant and can be investigated in no other way is the psychologist justified in giving misinformation to research subjects or exposing research subjects to physical or emotional stress.**
>
> **a. When the possibility of serious aftereffects exists, research is conducted only when the subjects or their responsible agents are fully informed of this possibility and volunteer nevertheless.**
>
> **b. The psychologist seriously considers the possible harmful aftereffects and removes them as soon as permitted by the design of the experiment. . . . [Principle 16. *Harmful aftereffects.*]**

Such a code of principles typically contains some absolutes. (Provision *a* above approaches an absolute requirement for voluntary consent, though the decision about when a "possibility of serious aftereffects exists" remains judgmental.) More of the principles will point to strongly desirable or highly undesirable practices that are nevertheless open to some kind of negotiation.

I would like to see some nearly absolute principles added that, I think, are essential to maintaining a relationship of trust between researcher and human subject, a relationship that is a prerequisite to society's continued tolerance of the behavioral scientist. Under very few circumstances is an investigator justified in violating a pledge of confidentiality given to a research subject, even though the interests of the subject are fully protected. The frequency with which hidden devices are used to identify supposedly anonymous questionnaires is deplorable. I would also like assurance that when an investigator *has* employed deception and subsequently explains his action to his subjects in a "debriefing" session, he presents the literal truth—and does not, as sometimes has been the case, use the session for further experimental manipulation.

However, in general, I would prefer to keep the absolutes to a minimum and would open even the few absolutes proposed to debate and to legitimate exceptions, under safeguards of a sort to be discussed shortly. Thus, I can imagine a research situation in which the covert identification of questionnaires might be an essential and justifiable method for checking on the effects of lack of anonymity on questionnaire responses.

The inherent limitation in ethical codes is the leeway they leave for human judgment and for balancing competing values. Without such leeway, any code would be unworkable; with it, the code is open to evasion. Application of ethical principles to real cases is literally a problem in casuistry and is vulnerable to the abuses that gave casuistry a bad name. In the principle I have quoted, what determines "when a problem is significant"? How much unsuccessful search do we require of an investigator before we allow him to decide that the problem "can be investigated in *no* other way"? How big a probability is a "possibility" of serious aftereffect, and how much does the experimenter have to hurt people for it to be "serious"? And who is to decide all this?

I am not criticizing the ambiguous wording of the principle. Insofar as there is no objective, common measure by which competing values can be "traded off," the fallibility of human judgment cannot be eliminated from decisions about the ethics of research. The question is whose judgment should it be and under what safeguards. What we need, therefore, are mechanisms of responsible "due process."

A due-process mechanism

At present, universities throughout the country are having their initial experience with one type of such a due-process mechanism. Through regulations promulgated in February and July 1966, the Surgeon General of the U.S. Public Health Service requires

every institution receiving a USPHS grant to develop principles and procedures governing the use of human subjects in research. A crucial feature of these requirements is a review of the judgment of each principal investigator or program director by a multidisciplinary committee of his institutional associates. Since the procedures became operative only on November 1, 1966, it is too early to report the experience that universities have had in administering these controls. After an era of laissez-faire, an attitude which can no longer be justified, I can safely predict that loud complaints from academic investigators will be heard for some time. Nonetheless, with only slightly less assurance, I also predict that a decentralized system of institutional review on the USPHS model will become the pattern for the social control of federally financed research on human subjects, including children. I think it is a desirable pattern, for all the nuisance it is creating.

What will this decentralized system accomplish?

1. It will assure the public and its representatives that the welfare of human subjects is protected by adequate safeguards. The acceptability of an investigator's procedures will be reviewed by others and will be justified to them. The requirement that the review committee be interdisciplinary promotes the development of common ethical standards across disciplines and professions and is likely to have a corrective influence on disciplines or subdisciplines that have become habituated to dubious practices.

2. Because the investigator's possible bias in regard to the ethical acceptability of research procedures is checked by making the judgment a matter of shared public responsibility, it will for the most part obviate the need for rigid and absolute rules and allow flexible judgment that takes the particulars of a research situation into account. The same considerations by which a jury system is a proper device for administering justice "beyond reasonable doubt" make a system of collegial review appropriate to the inherently judgmental issues research deals with.

3. At the cost of some initial confusion and inequity, it will encourage creative and responsible thinking within institutions as they formulate and revise the ethical codes under which the review committees will operate. Some may wish to keep formal principles to a minimum and evolve a kind of common law from the precedents that are established in borderline cases. Others may try to spell out more fully elaborated codes. Through their scientific and professional associations, the disciplines concerned would be well advised to watch these developments closely and to take the lead in preparing statements of principles for the institutional committees that reflect the special problems of their own areas of research.

4. It will avert the stultifying rigidity of Federal centralized administrative or statutory control over research practices.

I think the special problems of research on the behavior of children can best be dealt with in such a framework of decentralized institutional self-monitoring according to explicit principles and procedures, which can and should be modified as we learn from experience in working with them. Reviewing committees will naturally be slow to approve procedures that they are at all dubious about when the subjects of the research are young children.

A special problem

The issue that may demand the closest attention and give the greatest trouble is the one involving explicit parental consent. In regard to this problem, and to many others, behavioral research does not parallel clinical medical research [10] closely enough for the medical research codes to be particularly helpful.

The relationship of physician to patient, involving as it does the highly charged issue of life and death, can when it is diverted to research objectives be perverted to an unspeakable evil (as in the Nazi death camps), unless the strictest controls protect the patient's interests. If patients are to be able to turn confidently to their physicians for help, they must know that they will not be used in medical experimentation without their knowledge and consent. In the case of minors, parental consent is the legally required equivalent of the patient's consent. (Yet matters here are not simple either: advances in pharmacology that none of us would forego depend on the use of placebos and "double-blind" designs, practices that are hard to reconcile with the principle of voluntary consent.)

In contrast to medical research, much behavioral research, with children or with adults, is concerned with far less sensitive matters. When the requirement of explicit parental consent would defeat the purpose of an otherwise important behavioral study requiring a representative sample of children *and* no reasonable person would expect the study to harm the child or insult the parents' values, an exception to the requirement seems justifiable.

The sort of responsible review of the investigator's justification of his research procedures that the

Public Health Service is now requiring makes it possible to consider such exceptions on their merits. Review groups will have to develop their own guidelines for deciding when the explicit consent of a parent or guardian should be obligatory, when parents should be given the opportunity to consent implicitly by failing to object to an announced research plan that involves their child, and when the responsible head of an institution such as a school system or a school might appropriately consent to the research being done without consulting the parents. School authorities will of course base their decisions to give or withhold permission not only on their own judgment about what is ethical but also on the compatibility of the research with the school's educational objectives for the child. The latter judgments are more appropriately made by superintendents and principals than by investigators, review committees, *or* parents.

Respect for the subject

Lest I give the impression that the due-process mechanism the Public Health Service has decreed for American campuses will of itself fully allay the concern about the proprieties of research with children and other human subjects, which many social and behavioral scientists share with other citizens, I need to draw, by way of conclusion, a distinction between what is ethically permissible and what is ethically desirable. My own view is that the predominant cast of much permissible behavioral research falls short of the desirable in too often adopting a manipulative or condescending attitude toward its human subjects rather than a genuinely respectful, collaborative one.

Much public resentment toward the behavioral sciences arises, I think, from correct perception of this tendency toward manipulation. Review committees and codes of ethics will not directly improve this state of affairs because inevitably they are concerned with ruling out what is not permissible, rather than with making what is desirable prevail. If and as behaviorial scientists come more characteristically to grant their subjects the respect they accord to collaborators in an enterprise they understand and accept, they should, by the same token, help create a more favorable atmosphere for behavioral research. The styles of research that prevail may be more important than skill in public relations in creating a favorable "image" of behavioral science.

In research with children, an atmosphere of respect and care is particularly important. Improvement in what is normative practice in research in the behavioral disciplines must be the outgrowth of continued discussion in the professional societies and in the universities and of resultant changes in graduate training.

Such discussions are in process as a byproduct of the review procedures the Public Health Service is requiring of the universities. As a result of participating in them, social and behavioral scientists may come increasingly to realize that they have lost their innocence. They can no longer live in a world of simple good and evil in which their research decisions follow unambiguously from academic-scientific values. Like it or not, they are now faced with picking their way among conflicting values and resolving the conflicts as best they can. It comes to many of us as a surprise, though it should not, that the modes of resolving such conflicts are in the broadest sense inherently political.

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A TIME STUDY in a WELL-CHILD CONFERENCE

VICTOR EISNER, M.D. ● HELEN M. WALLACE, M.D.

Long waiting times in a clinic are well-known obstacles to adequate health care. When these are combined with unrealistic appointment schedules and overburdened personnel, the quality of care suffers, and both patient and staff satisfaction is impaired.

One tool for improving such a situation is a time study. This tool is not used as often as it might be because of a general feeling that an effective study is both difficult and expensive. In Berkeley, Calif., however, a simple time study has been used effectively in an uncrowded well-child conference to provide a baseline for evaluation and administrative changes.

The clinic in which the time study has been applied is jointly sponsored by the Division of Maternal and Child Health of the University of California School of Public Health and the Berkeley Department of Public Health. At the time of the study, the clinic held one 4-hour session a week and was staffed by one pediatrician, two public health nurses, and a nonprofessional receptionist from the local Neighborhood Youth Corps. In addition, a nutritionist from the School of Public Health gave demonstrations to patients in the waiting room, consulted on individual problems, and participated in staff conferences.

The clinic sees an average of 15 infants and preschool children each session, according to the local health department records for the past year. The public health nurses, under the guidance of the pediatrician, take the major responsibility for interviewing and counseling parents. The pediatrician sees each child at scheduled intervals for a history and physical examination and is available to the nurses for consultation or the evaluation of a child at any time. The final hour of each session is used for a staff conference at which each child is discussed.

This procedure results in three types of visits. A mother may bring her child for a "doctor visit," a "nursing visit," or an "immunization visit." The "doctor visit" includes the nurse's weighing and measuring of the child, a conference between the mother and the nurse, and a physical examination carried out by the pediatrician who also reviews the health history taken by the nurse. The "nursing visit" is similar except that the child is not seen by the pediatrician unless the nurse requests a consultation. Such consultations or "inspections" as they are called may be requested when the child has a skin rash or a respiratory infection, or when the child presents more obscure or complex symptoms of a health problem. The "immunization visit" is a return visit of a child to the clinic for immunization only. On these visits the nurse checks briefly to be sure that no infections exist and that the immunization has previously been ordered by the pediatrician, and administers the immunization.

Collection and analysis of data

In the time study, the time each child spent at the clinic and the activities of each member of the clinic staff were timed during four clinic sessions. Using simple forms, the receptionist recorded the times of arrival and departure of each child, and the nurses and pediatrician recorded the times they started and finished each activity, with the name of the child and the type of activity performed. This did not prove

difficult. It is estimated that the total time taken for recording was about 5 minutes per recorder for each session.

A total of 77 children were seen at the 4 timed sessions, or an average of 19 children per session, 4 children more than average.

The data were analyzed to find out how the children's time was spent in the clinic and how the clinic personnel used their time. In addition, because of the use of the waiting room for nutrition demonstrations, a study was made of normal waiting room load. The nutritionist's activities were not timed directly because it was difficult to relate them to specific patients and because they did not influence the time spent by the other clinic personnel.

In order to analyze patient time, the data sheets were examined to see how many minutes each child had spent in the clinic altogether and how many in each type of activity. Data tabulated on "doctor visits" included the time the physician spent taking the child's history and giving the physical examination, and administering an immunization; the time the nurse spent in conference with the child's mother, in immunization, and in weighing and measuring; the time spent by either nurse or physician during the same visit in an activity with a sibling or siblings of the patient; and the time the child spent waiting in the clinic when no member of his family was being attended—a figure arrived at by subtracting the time spent by staff in activities with the child and his siblings from the total time the child spent in the clinic.

For a nursing visit, the tabulations included the time the nurse spent in conference with the mother, in immunization, and in weighing and measuring, and the time the physician spent inspecting the child; the time spent by either nurse or physician with the child's siblings; and the child's waiting time. Tabulations on an immunization visit included the time spent in administering the immunization—considered to include any time used for taking the history or discussion—the time spent in service to a sibling; and the child's waiting time.

The findings

Calculations made from these tabulations produced an average physician time, nursing time, and waiting time for each type of visit. The figures showed that, on the average, each child spent 51.7 minutes in the clinic, 21.9 of which the child spent waiting, exclusive of the time he waited while other children in his family were being served. (The range between children was 20 to 90 minutes in the clinic and no time to 47 minutes waiting.) The pediatrician spent an average of 7.7 minutes (with a range of from 2 to 21 minutes) on each physical examination he made, including the history taking, an average of 3.5 minutes per immunization, and 2.2 minutes per "inspection." The nurse spent an average of 13.5 minutes (with a range of 4 to 40 minutes) in conference with the child's parent, 4.4 minutes on immunization (with a range of 2 to 15 minutes) and 2.1 minutes weighing and measuring.

The total professional time per child spent on a doctor visit was 9.1 minutes by the physician and 14.8 minutes by the nurse; on a nursing visit, 0.4 minutes by the pediatrician (with a range of 0 to 4 minutes) and 14.5 minutes by the nurse; on immunization visits, 6.3 minutes. The average amount of professional time per child for all types of visits was 5.5 minutes by the physician and 13.9 minutes by the nurse.

Use of professional time

Other calculations showed the proportion of each staff members' time in the clinic spent on various types of activities. This was achieved in two ways.

The first method was to total the amount of time recorded for each of a number of types of activities and to divide by the total available time. Clinic administration, which included setting up the clinic, cleaning up afterward, and posting health department records, was one activity. Others were immunization, weighing and measuring, nursing conferences, history taking and physical examination, and inspection of children. (Recording data in children's charts was considered as part of these activities.) Time not spent in these activities was recorded as "waiting." This included time spent waiting between patients and time spent in a short midmorning coffee break.

Victor Eisner, left, associate clinical professor of maternal and child health at the University of California School of Public Health, Berkeley, has for the past year directed the Franklin Well Child Conference he describes in this article. **Helen M. Wallace** is also professor at the school and chairman of its division of maternal and child health.

The second method of calculating the use of professional time was to multiply the average professional time for each type of visit by the total number of visits of each type in a year and divide the result by the total working time in a year. While there were some discrepancies in the results of these two methods, they were not great, probably because the study days did not represent an average for the year as a whole.

Both methods showed that a large amount of professional time was being used on activities not directly involving patient care. Method I showed that the pediatrician spent only 57 percent of his time with the patient and the rest—43 percent—in waiting; method II, that he spent only 46.1 percent of his time with the patient.

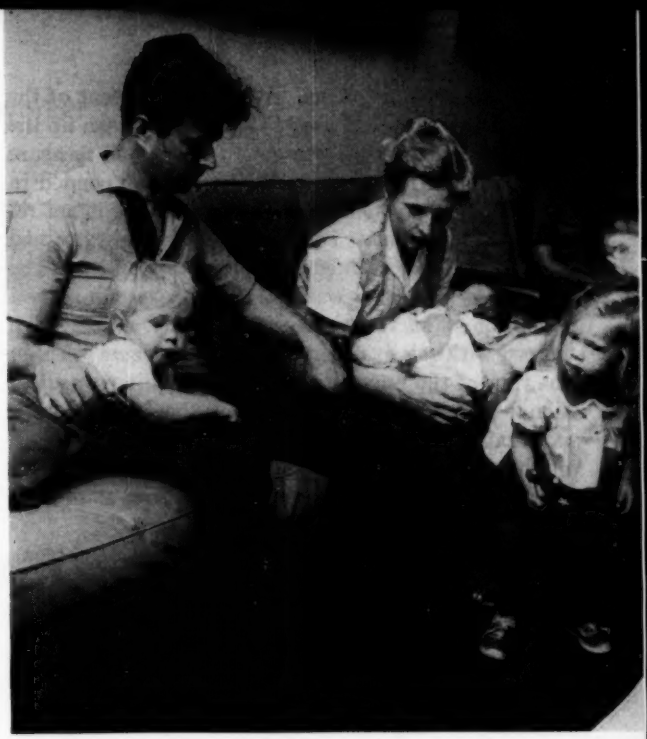
The nurses, according to method I, were spending only 66.2 percent of their time with the patient (58.2 percent according to method II), and a surprising proportion, 16.3 percent, on setting up and cleaning up the clinic, and in waiting, 15.5 percent. In addition, 2 percent of the nurses' time was going toward keeping health department records. The 66.2 percent of the nurses' time spent with the patient consisted of 57 percent in conferences, 5.5 percent in immunization, and 3.7 percent in weighing and measuring.

The study of waiting room load was made by tabulating, for each 5 minutes of time, the number of children who entered and left the clinic, and the number of children actually being seen by the nurses and pediatrician. The total numbers of patients for each 5-minute time interval were divided by the number of sessions to obtain an average number. The results showed a fairly constant waiting-room load from 9 a.m. to nearly 11 a.m. of one to four patients.

Significance of study

It proved to be relatively easy for the investigators to obtain the cooperation of clinic personnel for this study. Cooperation was solicited in discussions of the purpose of the study at clinic staff conferences during the month before its initiation. Since the purpose of the study was to obtain a baseline for evaluation of the clinic, with the possibility that administrative changes might ensue, a discussion of the types of changes that might result also took place at these sessions during which it was pointed out that the study was not being made because of dissatisfaction with anyone's work.

In spite of these prestudy discussions, two recording difficulties arose at the start of the project due to misunderstanding on the part of staff members. The clinic receptionist neglected to record times of the children's arrival and departure during one session, and on the first study day one nurse failed to separate weighing and measuring time from nursing conference time. These difficulties necessitated the extension of the study from the three sessions planned to four sessions and the discarding of the defective data.



A family in the waiting room of a well-child conference.

The analysis of this study required approximately 4 hours of the investigator's time and the use of a desk calculator. We required less than a full hour, divided into several sessions, to explain the study to participating staff members and to instruct them in the use of the data sheets.

Although the study was planned only to provide baseline data, it elicited certain facts that are of significance to the field of public health practice. For example, the fact that each child and his parent spend, on an average, 21 minutes of their time in the clinic waiting suggests that an opportunity exists for the extension of health education to other areas besides nutrition.

The use of the nurses' time, as found by the time

study, deserves comment. When 16.3 percent of the time of two nurses is used to set up and clean up the clinic and another 3.7 percent to weigh and measure the child, a fifth of the nurses' time is expended in procedures for which professional training is not required. Such duties could be performed by trained volunteers or by trained subprofessional aides. The untrained aide who was working at the clinic as a receptionist at the time of the study might have helped with some of these chores and so have released the time of the nurses for functions requiring professional training such as counseling the family or immunization. The study thus indicated that the clinic might absorb an increase of as much as 20 percent in the patient volume without any additional professional time being made available.

Equally significant was the finding that 43 percent of the pediatrician's time was spent waiting for patients, obviously a great waste of a professional resource. From the viewpoint of time alone, the study thus revealed that a reorganization of this clinic's procedures was necessary so that maximum use might be made of the pediatrician's skill. In ensuing discussions between the authors and clinic administrators, it was pointed out that the clinic would be making better use of the pediatrician if (1) he saw more children; (2) he served more actively as a consultant to the nurses; (3) he performed a review of records as part of planned studies; (4) he conducted group meetings of the parents in the waiting room; (5) the clinic incorporated medical treatment into the program, thus using the pediatrician's time on curative as well as preventive aspects of child health supervision in a program of comprehensive care.

The finding on the amount of the pediatrician's time spent in waiting also raised the question as to the effect idleness nearly half the time might have on a pediatrician in any clinic. Would the pediatrician remain interested or become bored? Would he feel that he was an integral part of the clinic, or a rather unnecessary appendage?

Followup

Several steps have been taken in this child health conference as an immediate result of the time study. Prior to the study the pediatrician was considering whether the clinic might not profitably use another nurse. The time study showed that another nurse was not needed, but rather that the need was to use the time of the available nurses more productively. The plan is now to increase the amount of nurses' time available to patients by training a volunteer to set up and dismantle the clinic, weigh and measure all children, and fill out the health department records. This step has been delayed by the resignation of the Neighborhood Youth Corps worker to take a permanent job elsewhere, thus depriving the conference of her services. Vigorous recruiting for a volunteer is in progress in the neighborhood of the clinic among mothers who are free during clinic hours because all their children are in school.

Because of the finding on the amount of time the young patients and their mothers are spending in the waiting room, the nutritionist is spending more time in the waiting room with them discussing food-buying practices, general principles of feeding children, and other problems. The group discussions of food-buying, which include current prices, comparisons of the nutritive values of various foods, and many suggestions for varying the family menu, have proved especially popular. We now notice mothers who return to the waiting room after their children have been seen to continue to participate in the discussion.

A rescheduling of "physician visits" is now in process to allow better use of the pediatrician's time. Among the uses contemplated for this time are the provision of services to unreached segments of the community, increased consultation to nurses, teaching groups of mothers, and efforts to integrate the activities of the clinic with other community activities such as health programs in the local school and in the health services supported by the Office of Economic Opportunity. Already the clinic is making efforts to encourage the previously unreached Spanish-speaking mothers in the neighborhood to bring their children in for well-child supervision.

Because of the demonstrated value of the time study as a method of self-evaluation in a well-child clinic, the Division of Maternal and Child Health of the University of California School of Public Health has been working with its students and with local health authorities to encourage the use of this simple tool. It seems to us that the time study would have particular value as a lever for raising the level of performance in those well-child conferences that have long waiting lists and long waiting periods for initial registration of infants after hospital discharge, and also in those well-child conferences that are so overcrowded that they are designed for infants only and terminate service on the child's first birthday. Thus, a time study could be one device used in tackling the almost universal problem of "preschool dropoff" in well-child conferences.

an occupational therapist and a social worker combine their efforts in . . .

a HOMEBOUND THERAPY PROGRAM for SEVERELY RETARDED CHILDREN

HOPE G. CURFMAN ● CAROL B. ARNOLD

For the past year, 30 Denver families with severely and profoundly retarded children have been served by an unusual program combining the services of a professionally trained social worker and a registered occupational therapist. The program is unusual in two ways—it serves children not often reached by social agencies and it brings its services into their homes. The Easter Seal Society for Crippled Children and Adults of Denver, Inc., through its Sewall Easter Seal Rehabilitation Center, sponsors the program with the help of a grant from the Denver Board for the Mentally Retarded and Seriously Handicapped.

Giving each child an opportunity to fulfill his potential has long been recognized as a goal of education, but the right of the retarded child to the same educational opportunity has been slow to receive recognition. However, many public school systems now include special programs for mildly retarded children (IQ's of 55 to 67). Denver's school system, for instance, has had special education classes for children with IQ's of 50 to 80 since 1948 and last year served about 1,650 children.

But, until recently, few community resources were available to meet the training needs of children considered moderately retarded (IQ's of 36 to 51), severely retarded (IQ's of 20 to 35), or profoundly retarded (IQ's of less than 20). Financially able parents can provide care in private schools, but even for them the needs far exceed the resources. Parents with limited means have little choice beyond institutionalization or letting the child vegetate at home. Only a few agencies can offer more than minimal service to those who keep their children at home.[1, 2]

Recognizing that a gap existed between the programs offered by the public schools and the resources of the two State institutions for the mentally retarded, the Colorado Department of Institutions in 1964 requested a grant from the State Legislature for expanding resources for the mentally retarded, and received $200,000. The money was to be allocated to boards incorporated by local communities to purchase services from existing agencies and to organize community centers for retarded persons in the community.

From this grant, the city and county of Denver was allocated $27,000, and in August 1964 the Denver Board for the Mentally Retarded and Seriously Handicapped was incorporated to administer the fund. The board conducted a small project involving nine severely and profoundly retarded children, primarily to give some relief to the parents, for about a year. Following this, the board made a grant to the Sewall Rehabilitation Center to develop a homebound therapy program to help both parents and children.

The goals of the program are these: (1) To assess and develop the potentialities of each child, to help him function with some independence and, at a minimum, to help prevent further physical, mental, and social retardation in him; and (2) to help the family increase its understanding of its retarded child and thereby to contribute more to his development while learning to live more comfortably with the problems

he presents. According to the plan, these goals were to be met by combining the services of a social worker and an occupational therapist and, wherever possible, by providing services within the community so that the child might continue to live in his own home.

The social worker makes the initial contact with the family to gather pertinent information on its social history and to acquaint the family with both her services and those of the occupational therapist. After setting up an appointment, she and the occupational therapist call on the home together. During this visit, they try to explain their work to the family. The occupational therapist concentrates on what she hopes to accomplish with the child; the social worker, on what she can do to help the parents. At the same time, however, they work together as a team.

Objectives

As retardation is always a family problem, the social worker's first objective is to help the family find more acceptable or easier ways of living with a difficult situation. She varies her methods as the needs of each family require. Most parents need continual ego support because they often feel frustrated and hopeless. In some cases, the mother requires extra help because no father is living in the home. The social worker's task is to help the family face reality, to assess its strength, and to constantly support its members. When indicated, she introduces other community resources such as a hearing evaluation, physical therapy, or referral to a day-care center offering a structured program. After she establishes a relationship with the parent or parents, she introduces the services of the occupational therapist.

The complete picture of the child is taken into account in setting up individual aims for treatment. These aims are to help the child attain what skill he can in performing the activities of daily living such as eating, dressing, and using the toilet; to help him make constructive use of toys; to help improve his motor and perceptual development; to provide support for the family; and to prepare the child for further training suitable to his ability.

1. ***The activities of daily living.*** For the profoundly retarded, the occupational therapist begins this training at the most primary level of functioning—feeding and drinking. Many of the children progress no further than learning to chew ground food and drink from a cup, but even so small an advance is important for nutrition and nursing care. Not all cases require training in feeding, but many parents can use suggestions for improving the eating habits of their children. The therapist offers training or suggestions as the case requires.

In some cases, the occupational therapist's aim is to improve skills ranging from putting on shirt and socks to buttoning large buttons. Many children can take *off* clothes, and if the mothers do not want this ability reinforced, no such training is given.

In regard to toilet training, the occupational therapist advises the mother about the length of time to leave the child on the toilet and how to give praise or reward for accomplishments and encourages her to have patience and perseverance. The cultural patterns of the homes have a direct effect on this aspect of training, and some mothers cannot cope with their children's problems because of shortcomings in their own backgrounds.

2. ***Constructive use of toys.*** In some cases the children have been deprived of opportunities to play with toys and, consequently, of the experience of learning through manipulation and oral stimulation.

Some families cannot afford to buy toys that the child would quickly destroy. Most of the toys the occupational therapist finds in use are unsuitable for the hyperactivity and roughness of many retarded children. Most mothers, however, are eager to know what types of toys they should give their children, and the occupational therapist is able to help them select suitable playthings.

3. ***Motor development.*** With the profoundly retarded child who cannot even recognize a toy, the occupational therapist begins by using the idea of body image and the concomitant awareness of environment. She used, for instance, the sitting balance, standing balance, and the crawl position to exercise three of the most severely retarded children.

Hope G. Curfman, left, **and Carol B. Arnold** until recently worked together as social worker and occupational therapist, respectively, at the Sewall Easter Seal Rehabilitation Center in Denver. Mrs. Curfman is now a social worker in the Denver public school system. Mrs. Arnold is now devoting full time to raising her two children. She was once director of occupational therapy at the State Home and Training School, Wheatridge, Colo.

Helping children gain control of the head and trunk is important because without it their visual stimulation is limited and they are difficult to feed.

4. ***Perceptual development.*** Perceptual training is limited to the area of tactual stimulation through the use of large puzzles, graded pegs, and materials of different consistencies such as cotton and sandpaper. The occupational therapist also uses games developed for culturally deprived and moderately retarded children such as picture lotto, chutes and ladders, and candyland for teaching picture identification and color and form recognition.

5. ***Support for the family.*** In some instances, the parents have given up hope that anything can be done for their retarded child. Other parents are unrealistic in their expectations of what their child could do with some training. The homebound program gives the parents first-hand experience with the methods that could be used to help the child and an opportunity to see the progress or lack of progress in the child. After some experience with the worker, they sometimes begin to think of ways to help the child themselves. For example, several mothers have suggested the use of a walker or chair, and several of the more observant have learned *how* to play with their retarded children by watching the occupational therapist at work.

6. ***Preparing for the kind of training most suitable for the child.*** Whenever possible, the workers try to prepare the child to go into other programs such as the preschool group at the Sewall Rehabilitation Center or a group program for trainable older retarded children. They assist the families in making the transition in each case and supply the schools with helpful information.

Methods

During her first visit to the family after the initial interview with the social worker, the occupational therapist brings colorful and sturdy toys with her, including noisemakers and toys requiring dexterity and coordination, selected according to the information in the social history. On later visits, she ascertains what the goals are for each child and what equipment she needs.

Because all toys and equipment used in the homebound program have to be carried by automobile, none are heavy, bulky, or messy. But a small cutout table, a kindergarten chair, and a playpen pad are part of the standard equipment. The pad is inexpensive and easy to carry and makes it possible for the occupational therapist to sit on the floor with the child if he cannot balance himself on the chair. Depending on the case, she brings in a relaxation walker for use on trial.

The occupational therapist uses toys to promote the recognition of color, gross and fine coordination of the arms and hands, form perception, and so on: a color cone; two simple puzzles; a graded, round peg set; a nest of round color cups; a large ball; a squeaky animal toy; a button box; a string with beads; a pounding toy; and small blocks. She introduces other materials, depending on the child's needs and ability, such as scissors, paper and paste, clay, pictures, lacing projects, a loom, and games.

During the first visit the occuational therapist arranges a time for regular visits with the family every week. The agency makes an exception to a firm schedule if necessary, as in the case of a mother who works on shifts.

The mothers' group

In addition to bringing services into the home, the center also holds eight weekly 1-hour sessions in group counseling for those mothers the workers think would benefit from such an experience. In the original group, this was about half. The other mothers of this group participated in individual counseling only because the social worker thought they would not profit from group work or because they could not attend the meetings.

The mothers who attend the sessions bring their retarded children to the center, and while they are attending the session with the social worker, the occupational therapist conducts a simple program for the children divided into free playtime, snacktime, and project time. The free play introduces the children to the new situation, the clinical environment, and each other. Snacktime gives them an opportunity to practice table manners and to develop the ability to share with others. And the project time gives them an opportunity to learn simple methods of coloring and cutting and gives the occupational therapist an opportunity to observe their cooperation and interaction. However, because of the children's wide range of ability, this part of the program cannot provide the children with individual therapy. Nevertheless, providing this service simultaneously with the sessions has proved to be the best method of involving the mothers and of establishing the focal point on which the group discussions begin.

The goals of the group program for the mothers are these: (1) To provide specific help in living and dealing with feelings; (2) to create an environment in which feelings can be aired; (3) to provide specific help with practical problems of management; (4) to provide group support through the exchange of ideas between members of the group and the leader and to help minimize the feeling of isolation; and (5) to encourage the use of services offered by the center through the social worker-occupational therapist team and those of other community organizations.

The specific issues discussed at these sessions include ways of handling questions from others about "what was wrong" with the children; the need for "escape valves" for anger; methods of discipline and other problems of management; and long-range planning for the children. The mothers in the first group asked for a tour of the State institution for the mentally retarded near Denver and nine went on such a tour. At a meeting held after the tour in which they discussed their reactions and expressed their feelings, all nine said that they now felt better able to plan for placement of their children if necessary.

The center has decided that, on the whole, group counseling as a part of the program for the mothers who could profit is beneficial. The greatest achievements are the minimizing of the feeling of isolation, the passing on of practical suggestions for dealing with problems of management, and getting the mothers to discuss long-range planning.

Case illustrations

So far 30 families have been involved but only 20 at any one time. As a beginning, the board selected 20 cases after review by its admission committee. All 20 children originally selected were severely or profoundly retarded and physically handicapped and lived in their own homes (with one exception). All were evaluated medically and, if possible, psychologically, before acceptance. Their ages ranged from 3 to 18 years, the average being 8 years; their IQ's, from "untestable" to 50, the average being 24. All families of the children selected were living in Denver, and most were on the lower socioeconomic levels. They consisted, in almost even proportions, of Anglo-Americans, Negro Americans, and Spanish Americans. The medical diagnoses for the children reported the presence of Hurler's Syndrome, Down's Syndrome, microcephaly, postmeningitis, "brain damage," and "mental retardation, etiology unknown."

The following examples taken from these first 20 cases illustrate the methods used by the social worker and the occupational therapist in working with these children.

Peggy B and Larry S: These children present a contrast, though both are about 8 years old, have about the same IQ—an estimated 20—and both function at about the 2-year-old level. Peggy has been diagnosed as having hypothyroidism, for which she is receiving treatment; Larry, as having organic brain damage with chronic otitis, mild conductive hearing loss, hypospadias, repaired cleft palate, and convulsions. Both children had very limited speaking ability.

In the case of Peggy, community resources were used to meet her needs while she lived in her own home; in the case of Larry, the goal was institutionalization. The need for different goals became apparent in working with the children and their families even though their functional levels are about the same. The workers determined that both children could profit more from the stimulation received in a group of other children with similar disabilities than from being at home all the time.

Larry S: The pressures of Larry's home increased his negative behavior. During the home visits, his mother would hover over him and prod him verbally. Though she said she knew his ability was limited, she was constantly seeking confirmation that he was improving. He needed to be out of this environment for therapy to be effective.

One of the aims for Larry concerned feeding, not as a function of motor ability, as Larry could use a spoon and cup, but to stimulate his poor appetite. After a visit during lunchtime, the occupational therapist decided that the mother was overfeeding the child and forcing him to eat larger portions than he should eat. She suggested that, since Larry enjoyed a large breakfast, his mother might omit the noon meal or make it very light and give him his main meal in the early evening.

Larry had good fine coordination, but, because his balance was poor, the occupational therapist emphasized activities involving gross coordination, activities difficult to offer in the home. Larry was uncooperative much of the time and would not perform the activities unless he wanted to end the therapy session. When the occupational therapist disciplined him for his actions by showing disapproval, by facial or body gestures and by spanking his hands, he would begin to follow instructions. He resisted efforts to

teach him to dress, however, because his mother had punished him for removing his clothing.

The social worker meanwhile was counseling the parents. Mrs. S, through the mothers' group at the center, was able to air her feelings regarding Larry and her problems concerning a younger cerebral palsied brother and a normal sister. Her husband, who was pressuring her to place Larry in the State institution, told the social worker, "It's either him or me." Mrs. S, in resisting this pressure, had developed stomach ulcers and had become obese from emotional overeating. She was extremely dependent on her own mother and felt torn by the demands of the two other children. After a single interview with the social worker, her husband let up on his threats. With the social worker's help, he recognized that he felt under tremendous financial pressure to provide for two severely handicapped children, that his real concern was over the effects of both retarded children on the normal little girl, and that the conflict over Larry in the home was becoming a wedge between him and his wife.

During a brief hospital stay for Larry, the mother realized how much calmer the home was in his absence. She also realized that the problem of caring for Larry would become increasingly greater. Recently she enrolled the normal child in a neighborhood cooperative nursery school and signed the application papers to the State institution for Larry.

Although there are still many unsolved problems in Larry's family, his parents have shown the capacity to act. The occupational therapist was able to demonstrate to the mother that she was making unrealistic demands on the child, and both workers helped her face his limitations. Family friction lessened, and a realistic plan for Larry and his sister was carried out.

Peggy B: Resources within the community made institutionalization for Peggy B unnecessary. The occupational therapist worked with Peggy on dressing skills, perception techniques, and increased hand coordination. At first, she found it difficult to motivate Peggy because of the child's dependence on her family, who loved and accepted her as "the baby" of six children. Her parents put no pressure on her to acquire new skills. However, she would usually try to complete the activities given her by the occupational therapist.

When the mother did not give Peggy her medication as prescribed by her doctor, the child was logy, uncoordinated, and unable to perform satisfactorily. The occupational therapist pointed this out to the mother to impress upon her the need for the medication if Peggy was to improve. The mother was helped by the social worker to face her need to keep Peggy "the baby," and when the occupational therapist demonstrated to her that Peggy could acquire new skills, the mother seldom failed to administer the medication. She became active in the mothers' group at the center, and her opinion that the family could provide the loving care Peggy needed better than a large institution was reinforced by her tour of the State institution. This completely accepting family became interested in Peggy's activities and responded accordingly.

Larry's presence in the home caused mounting friction, but Peggy's was a focal point for family concern. After working with the two for several months, the workers felt that both children would gain from a group situation: A group would relieve Larry of the pressures of home and give Peggy more goals to attain. Both were, therefore, enrolled in the preschool group at the Sewall Center.

Donny P: This child, with an IQ of about 10, was diagnosed as being profoundly retarded and having bilateral glaucoma and mild seizures. He had spent 9 years lying in a crib, and was fed by a bottle. His mother, responsible for the care of nine children—five of her own and four of her deceased sister—had little time to spend working with Donny on new feeding skills; nor could she participate in the mothers' group.

When the occupational therapist tried to make Donny take food from a rubber-coated spoon, he resisted violently because he was not used to being held upright. Taking his age and blindness into account, the occupational therapist decided not to pursue the spoon feeding but rather to concentrate first on increased body balance and body awareness.

She next began working on sitting and standing balance and head control. At first, Donny was unable to bear any weight on his feet but would crumple to the floor; nor could he sit up straight. After the occupational therapist had worked 6 months with him, he stood with support and was bearing weight for about 5 minutes. After observing the occupational therapist's work with Donny, the mother and older children started working with him. The occupational therapist introduced the idea of a relaxation chair to try out with Donny. She explained that even though Donny was profoundly retarded it would be stimulating to him to be in the

living room with the family and that it would help him to change position from constantly lying in bed. When the family showed interest, the social worker procured the chair, made to specifications, from the Goodwill Industries.

Johnny F: In the case of Johnny, a 3½-year-old child of about the same mental age as Donny but with eyesight, the services of the homebound program did not meet with success. The father had deserted his family, and the mother, plagued with severe emotional problems, rejected Johnny.

A child welfare worker from the public agency had prepared Mrs. F for the homebound program, but she was unable to accept the service. Ambivalent at first, she did make feeble attempts to work with the occupational therapist on feeding skills. But she consistently broke appointments. Many other family problems complicated the issue and drained the mother's limited capacity. The only contribution the program could make was to provide additional diagnostic material for the child welfare worker in her long-range plans for the family.

Lloyd H: A 9-year-old boy diagnosed as having brain damage following meningitis, Lloyd H was at first hostile and uncooperative. He had previously been placed in a preschool age group for severely retarded children, but he had regressed to the point of wetting his pants, spitting, sitting on his hands, and banging his head. The occupational therapist spent most of her time during the first month's visits talking with the mother and letting Lloyd get use to having her in the home.

She used Lloyd's interest in playing ball as the focal point for working with him, and she developed many variations—tossing balloons, bouncing clay, and hitting a punching toy. He began to talk, and though his speech was unintelligible at first, in a few weeks phrases such as "bounce the ball" became clear. He soon gave up wetting his pants, though he continued to sit on his hands until the last month of the program. Although he continues to hit himself when frustrated and angry, his mother has become more aware of ways to channel his negative behavior, and she is helping him overcome this reaction.

The role of the social worker in relation to Mrs. H was to help increase this mother's understanding of her retarded child's behavior, to help her find acceptable ways of releasing her feelings, to help her substitute positive for negative methods of discipline, and to reinforce the activities of the occupational therapist. Mrs. H was a member of the mothers' group and was also seen individually by the social worker.

Seven of the children in the first group in the homebound program became involved during the year in other training programs such as Sewall's preschool group, a program for trainable older retarded children, and a program at a training school. Late in the program, two children were accepted by a private school for exceptional children, one was referred to a cerebral palsy center, and another to Sewall for further evaluation and intensive therapy.

Evaluation

As with any new program without a chartered course, problems have occurred. Some problems are inherent in the program itself. As the program centers on the severely and profoundly retarded child, only very small gains can be expected. Several of the children who have been involved are so severely retarded that the only movement is regression.

Compensations are found, however, by the staff members in the favorable responses of the parents to the program. In it the parents see something specific being done for their children, and usually they can see some progress. They frequently say to the workers, "At last someone is doing something for Susie," or "Stevie looks forward to your visits."

The program is continuing in cooperation with other agencies in much the same way. Emphasis at this time is on group stimulation for the children.

A program such as this does, in part, fill the gap between programs offered by the public schools and State institutions. Most of the children served are continuing to live in their own homes and are receiving therapy geared to their individual needs. At the same time, families are being helped to live more comfortably with the problems of a retarded child in the home. Apparently, the entire needs of the family with a retarded child are better met by the combined services of the occupational therapist and the social worker than they could be by either working separately.

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[1] Dittmann, Laura L.: Home training for retarded children. *Children*, May–June 1957.

[2] Cianci, Vincentz: Home training for the mentally retarded. *Children*, May–June 1955.

a social worker from a child guidance clinic provides . . .

GROUP COUNSELING of MOTHERS in an AFDC PROGRAM

DAVID KEVIN

Several months ago, a psychiatric social worker in a child guidance clinic (the author of this article) conducted a 6-month demonstration in group counseling of mothers selected from a public assistance caseload because of evidence that they were inadequately caring for their children. The results seemed salutary enough for this type of approach to the protection of children to be given serious consideration as a complement to individual counseling both by child guidance clinics and by public welfare agencies.

The Protective Services Unit of the Alameda County Welfare Department from which the mothers were selected was established in 1961 to provide more intensive services to families on public assistance, especially in the program of aid to families with dependent children (AFDC), in which there was evidence of neglect or inadequate child care. As part of its intensive services to these families, the unit became increasingly active in making referrals for psychiatric evaluation and psychotherapy to the East Bay Clinic for Child Psychiatry operated by the California State Department of Mental Hygiene. Gradually it became evident to the clinic's chief psychiatric social worker that all the families referred had multiple social and economic problems that were integral parts of the children's emotional and behavioral difficulties. It also became evident that the child referred to the clinic might not be the most upset child in the family.

Like most clinics serving children, the clinic used a lengthy evaluation procedure. It, therefore, seemed possible that many cases referred to the clinic by the welfare department dropped out because of the time involved and because of the failure of the child's mother to understand the evaluative process. At any rate, many evaluations were never completed because the mother and child never returned. This fact seemed to imply that a more appropriate approach needed to be taken to these families.

The psychiatric social worker, therefore, proposed to conduct a demonstration of group counseling of the mothers of children referred from the Protective Services Unit for treatment, in place of evaluation and treatment of the children. Two hypotheses underlay this proposal:

1. Through group counseling, the mothers would be able to improve their ways of coping with their difficulties.

Based on a paper presented at the 1966 meeting of the American Orthopsychiatric Association.

2. The effects of counseling the mothers only would noticeably alleviate the children's behavioral difficulties in school and in the home.

Reports from the unit workers and the mothers themselves were expected to provide necessary information about the adjustment of the children.

Initial planning stage

The first step was a discussion between the psychiatric social worker and the supervisor of the Protective Services Unit to work out plans for its implementation. Both agreed on the necessity for bringing the child welfare division's administrators into the initial planning, and therefore arranged for the chief and the assistant chief of the division to meet with them on several subsequent occasions. In these meetings, the possibilities of the proposal were explored fully from the viewpoints both of the welfare department and of the clinic in relation to the demands on the time of the unit's workers, the potentials for inservice training, and the possibilities of eventually incorporating the group counseling method into agency structure. The result was an agreement that the clinic would undertake the proposed experiment with the help of the division and that the administrators of the division would be kept informed of its progress.

The next step was for the psychiatric social worker to hold a short series of meetings with the supervisor of the Protective Services Unit and the unit's four workers to determine criteria and methods for selecting mothers for the project; to discuss problems related to the confidentiality of information that would come out in the discussion group, especially information that would have a bearing on the mother's eligibility for public assistance; and to work out methods for training the workers for the group leadership task. The criteria for selection agreed upon were:

1. The mother would have to be the head of the family. The selected mothers would be those responsible for the care and management of their children in their homes. Therefore, unwed mothers who lived with their own mothers would be excluded.

2. The mother would have to have a child or children under teen age. The exclusion of mothers who had teenage children only was based on the theory that little change could be brought about in teenage children through counseling their mothers only.

3. The mother would have to have at least one child who was showing behavior problems at home or at school.

4. The mother had to be stable enough emotionally to be able to relate to other mothers in a group. Mothers who appeared to be severely retarded or disturbed were excluded because it was imperative for the group members to understand each other.

5. The mother would have to be between the ages of 20 and 40. Those who were younger were excluded as likely to be living with their parents. Those who were over 40 were less likely to have young children and more likely to be fixed in their attitudes toward child rearing.

6. The mother would need to have ready access to public transportation because transportation difficulties could discourage attendance.

Following the establishment of the criteria, there was general agreement that each worker in the unit would contact all the mothers in his caseload who fulfilled these criteria, inform them of the possibility of joining this type of group, and encourage their voluntary participation.

The question of confidentiality was regarded as posing no problems because the psychiatric social worker, who was to conduct the group counseling, had no official relationship with the welfare department. However, if any questions were asked by the mothers relating to eligibility, the mothers were to be referred by him to their public welfare caseworkers for additional information or clarification.

The 6-month time limitation was set on the basis of several assumptions: (1) That the mothers would have trouble making arrangements for a longer period of time for transportation to the clinic and for the care of their children while they attended the meetings; (2) that they would have difficulty remaining absorbed in a group for a longer period, particularly one extending into the summer when their children would be out of school; (3) that 6 months would be a sufficiently long time to produce evidence of change if any were to occur.

Group composition

The unit workers suggested participation in the group to 34 mothers and pointed out that this was an opportunity to talk over their problems with other mothers in circumstances similar to their own and that through such discussion perhaps find better solutions for their problems in child rearing and home management. Ten of these mothers—eight Negro,

one Mexican American, and one Caucasian—agreed to participate. They included:

- Four mothers housebound by chronic depression so severe that they could not maintain their households or provide even minimal care for their children.
- Two extremely hostile and suspicious mothers who were overtly aggressive toward the welfare department and its workers and who in their child care were rigid and demanding.
- Two mothers who had had psychotic episodes: one was undergoing a severe depressive reaction; the other was so ambivalent that she was unable to make decisions.
- One mother with a severe drinking problem and a marked speech difficulty.
- One mother who frequently suffered from psychosomatic ailments such as allergies and headaches.

The psychiatric social worker sent each mother a letter informing her of the purpose of the counseling sessions and the date and hour of the first session and inviting her to attend.

The attendance fluctuated markedly until the end of the third month, at which time the group's membership stabilized at seven. The three mothers who dropped out were the most ambivalent and suspicious in the group. One had marked difficulty in transposing experiences into words.

There were several practical problems that influenced attendance: (1) Numerous medical appointments for the mothers of children at the county hospital that conflicted with the hours of the group session; (2) a long rainy spell that discouraged those who had to wait for buses; (3) unexpected difficulties in arranging child care; and (4) a 3-week illness on the part of the psychiatric social worker. By the end of the third month, most of these obstacles had been overcome.

The psychiatric social worker's role as group counselor varied with the stages of group development, the themes of the discussion, and what happened among the members. However, he always provided an urn of coffee for each session, thus showing the group that he could accept them and give to them without making demands. Taking coffee together provided the group members with a pleasant way to begin each session, helped them warm up to the group gradually, and offered the counselor an acceptable excuse for a break when the tension became too high for one of the members to tolerate. It also provided the counselor with some insight into the nature of the members' social interactions.

For example, in one of the early sessions of the group, the leader invited the members to have coffee. All except one went to the coffee urn and chatted about how nice it was to have the coffee available. Although it was only 11:30 a.m., the mother who refused coffee said that it kept her awake. In this way she seemed to be informing the leader that she could not be bribed by an authority figure as could the others. However, later on after the psychiatric social worker had focused the group's attention on her child-rearing problems, thus giving her an opportunity to voice her frustrations, she arose to get herself a cup of coffee.

Recurrent themes

One recurrent theme in the earlier group sessions dealt primarily with problems of child management and discipline. While on the surface these problems did not seem different from those encountered in normal parent-child relationships, discussion revealed them to be much more intense and, in some cases, symptomatic of pathological relationships that seemed to arise out of the mothers' status as heads of poverty-stricken, fatherless families.

Most of the mothers felt overwhelmed by the necessity of having to take on the roles of both mother and father and by the never-ending, unrelieved demands of their children for attention, discipline, affection, understanding, and time. They had responded to this feeling in one or more of the following ways:

- Placing older children in quasi-parental roles in relation to themselves and their younger children.
- Becoming overly critical of their children, especially the boys, and demanding that they be inordinately obedient and quiet, with the results that younger children became infantilized and adolescents reacted with rebellion often expressed in antisocial behavior.
- Being unconsciously seductive with an older son, an attitude that either led the boy to leave home or to become feminized or both.
- Becoming competitive with a daughter who had given birth out of wedlock and taking over the mother role for the daughter's child.
- Sinking into a state of hopelessness and apathy.

A second recurrent theme had to do with the mothers' feeling that they had married or had alliances with men who were weak, ineffectual, deceiving, brutal, or alcoholic. There was, in fact, a recurrent hostile ridiculing of men in general as manipulative

toward women and as having one goal only in mind, their own sexual gratification.

A third recurrent theme was connected with the mothers' methods of coping with a hostile environment. They painted black pictures of official institutions—particularly the welfare department and the county hospital—and their staff members. One widespread complaint was against the constantly changing public assistance workers, who, they implied, knew less about people's legal rights, privileges, and limitations under the welfare and institution code than the clients themselves. They repeatedly told of arriving for early morning appointments at the county hospital and being kept waiting all day and even sometimes being asked to return the following day. They also expressed hostility toward the public utility companies and retail credit stores. In the mothers' minds there was apparently little difference among all these "enemies."

A fourth theme concerned difficulties in getting credit and in shopping for and preparing food.

A fifth theme dealt with the purposes and effects of the group meetings.

Counseling techniques

In counseling the group, the psychiatric social worker used an approach primarily directed toward helping the mothers increase their coping capabilities. He, therefore, encouraged them to discuss their experiences and frustrations with each other. When they did so the group members became closer to each other as they found they had common experiences despite their different ethnic and cultural backgrounds. Following the establishment of greater empathy among them, the worker encouraged them to exchange information about their methods of dealing with their problems. He asked direct questions about how they shopped, how they prepared food, how they disciplined their children, and the like. This type of guided activity helped keep their attention focused on difficulties relevant to child rearing.

Only rarely did the worker feel it necessary to directly support the mothers' feelings since the mothers were supportive as well as directive in their comments to each other. For example, the previously psychotic mother who was so ambivalent and indecisive in dealing with her children was told by members of the group that they would not tolerate constant whining demands from their children. They pointed out that her way of saying two opposite things to her children at the same time was confusing to them and to herself.

While the worker rarely focused the discussion on feelings as such, the mothers' cathartic expression of feelings of futility, rage, and cynicism tended to reduce the strength of such feelings. As a result, the members of the group became able to differentiate among the targets of their hostility more realistically. In so doing, they tended to modify their perception of public assistance workers and began to see their workers in the Protective Services Unit as being well informed, capable, and genuinely interested in their welfare.

Late in the group's existence, after several mothers had reached the point of feeling some sense of mastery over their environment, a few of them became involved in community organization activity through a neighborhood community action program. They worked to reduce vandalism in their neighborhoods and to attain more nearly equitable rents and better maintenance from their landlords. The group counselor encouraged them in this activity and in discussing its successes and failures. He also encouraged them to discuss additional steps they might take to better their living conditions.

When the mothers expressed bitterness at exhorbitant interest rates in credit buying, the counselor asked them whether they would like to have an expert on credit speak to them. They responded with enthusiasm, and so the counselor invited a representative of a credit union to talk to them at a subsequent meeting. Similarly, when the mothers discussed food shopping and preparation, the counselor arranged for a home economist from a consumer's cooperative to speak to them. Obviously, the kind of practical information taken for granted by middle class housewives had never been made available to these mothers. The counselor believed that it could not only help them with their day-to-day management problems, but also could help build up their self-confidence.

Group interaction

The members of the group seemed puzzled at the early meetings. Their interaction with each other was highly tentative. They gave most of their attention to the counselor with the implicit expectation that he would behave like most of the middle class authorities they had encountered—that he would be critical and tell them how to run their lives and to solve their problems. They were surprised and

even resentful when he did not respond in this manner but left it up to them to work out their own problems.

As the mothers turned to each other and each carried the dual role of helper and helped, they became freer in revealing their current and past relationships and difficulties. They went beyond looking for methods in child rearing and began to seek reasons for their attitudes toward their children. For example, one mother came to see that because of feeling that she was getting nothing for her efforts she could not praise or encourage her children, who were, therefore, in constant search for attention and not particular about the kind they received.

The mothers moved from a sensitive embarrassment at their common status as recipients of public assistance to a pride in being a member of a group of mothers who were working together to solve their problems. They expressed the feeling that because they were trying to influence their own lives they were different from some other mothers in the AFDC program. They also saw themselves as different from mothers who were not on public assistance.

As the sessions progressed and the mothers told about how they were trying to solve their problems, the influence on the others of the verbally dominant members of the group became apparent. Therefore, when the counselor learned that a member of the group had achieved some success in attacking certain problems of child rearing, home management, or interfamily relationships, he asked that member to tell the group about her experience in detail.

As the members of the group became better acquainted, some of them began to stay on for another cup of coffee and for a chat after the session had officially ended and the counselor had left. First, two or three members stayed and later most of the group. These postmeeting gatherings led to real friendships among some of the members. What might seem to be an unimportant social experience was an important advance in socialization for these isolated mothers, one that helped them achieve a greater sense of identity as persons in their own right.

Mothers' assessments

In the final sessions, the counselor attempted to get the members to assess their experience in the group and its meaning to them. This turned out to be a very difficult task for them. They seemed to be very much embarrassed, as if unaccustomed to looking objectively at themselves in a specific situation.

David Kevin, a graduate of the University of California School of Social Welfare, Berkeley, is the chief psychiatric social worker at the East Bay Clinic for Child Psychiatry in Berkeley. He has served as a consultant in group counseling to the Alameda County Welfare Department, to the Family Service Bureau of Oakland, and to teachers of the educationally handicapped in the Contra Costa County schools, all in California.

They did, however, express appreciation for having a time for themselves once a week free from household chores and the demands of children and a place to go. (Few people realize how rarely mothers in the AFDC program have a chance to go anywhere.) Some of them also reported, directly or indirectly, one or more of the following effects of their participation in the group on themselves or their children:

- Some change in attitude on the part of the mothers toward their children: More consistency in their discipline, less perfectionism, more generosity with praise, and less criticism.
- Some evidence of changes in the children's behavior: Better behavior in school—or at least fewer complaints from the school about the child's behavior—and less tension in the home.
- A lifting of depression and apathy with resultant increased activity in home and neighborhood. (This was especially apparent in the four mothers who had become active in neighborhood work.)
- Increased understanding of their rights, privileges, and responsibilities under the welfare laws. Some of the mothers attributed this to the interchange during their postmeeting discussions.
- A lessening of a sense of guilt over being a recipient of public assistance.

Thus, the oral reports of the mothers themselves indicated that the group experience had provided them, in varying degrees, with more accurate knowledge of their environment and ways to deal with it, more accurate perception of their relationship with their workers, their neighbors, or persons in authority, and better tools for coping with the environment.

In the area of personal relationships, the mothers' reports indicated some increase in understanding of their children's needs for more individual attention, for more commendation, for less unrestrained criticism and punishment, and for more consistent firmness in relation to unacceptable behavior and in-

creased ability to see their children as individuals with individual personality needs.

Improvements in areas of ego mastery were indicated by their movements from pronounced social and emotional isolation to involvement in neighborhood and community affairs.

In symptomatology, the mothers' reports indicated pronounced decrease of depressive reactions.

Workers' observations

The more objective reports from the unit workers confirmed the reports of the mothers. They received direct evidence from the schools and hospitals regarding improved attendance and behavior. They saw positive changes in home management reflected in greater neatness and care. They saw positive changes in self-care and dress in the mothers. They found evidence of less tension in the households. They observed the involvement of some of the mothers in neighborhood councils and even in spearheading social action, such as getting out petitions for a larger rental allowance in their budgets.

The following are excerpts from the workers' observations made a month after the group ended:

Mrs. J: She is more accepting of the idea that her children's behavior is connected with her relationships. She no longer projects the blame onto the school, the public welfare department, or the children's father. Her teenage daughter, Delia, formerly a frequent runaway, has not left home during the past 4 months, and has completed her school year with the help of the home instructor and will be accepted in the regular school session in the fall.

Mrs. M: Before her participation in the group, she was frequently depressed and unwilling to get out of bed. She seemed on the verge of another mental breakdown. Her children were doing poorly in school and their attendance record was very poor. Her house was unkept. After participating in the group, she asserted herself with agency staff members and other people. She can now express her feelings and talk about her problems. Her depression is barely noticeable. She has become involved in the activities of the Economic Opportunity program in her neighborhood and in the Boy Scouts program. She feels more worthy and her children are proud of her community work. She is now able to control her children and is clear about her parental role. She feels she has some control over her own and her family's destiny.

Mrs. C: She has shown a most dramatic change in her personal appearance, in her abilities to manage her household activities, and in her relationship with her children. She is able to discuss her problems freely now and to ask questions when she is confused. Before participating in the group, she never had visitors. Within the past 3 months she has become involved in a neighborhood improvement group that has met at her home. The most important change in her children is their good school attendance.

In addition to the two major hypotheses on which the project was based—that group counseling of the mothers only would (1) improve the mothers' coping mechanisms and (2) alleviate the behavioral difficulties of their children—the project tested a number of implicit assumptions. These were that people from the lowest socioeconomic bracket could become fully involved in sustained treatment, could achieve a degree of motivation that would provide an impetus to attend sessions regularly and on time, and could achieve an intense involvement in treatment without making a money payment. There was also an implicit assumption that for these achievements the treatment approach to this group required a wider flexibility than conventional group psychotherapy. All of these assumptions seemed valid for the group of mothers who participated in the demonstration.

It would be of great pragmatic consequence to have this type of demonstration replicated. If similar results were obtained with similar groups, they would strongly indicate that this type of group approach, as a complement to the individual efforts of public assistance or protective services caseworkers, holds real promise for helping many mothers in the AFDC program cope with the kinds of problems that impede their ability to provide appropriate care for their children and thus for helping them improve the quality of their own and their children's lives.

Always a way must be found for bringing into one's solitary place the settled look from another's face, for getting the quiet sanction of another's grace to undergird the meaning of the self. . . . Here at least one is dealt with, encountered, vanquished, or overwhelmed—but not ignored. It is a strange freedom to go nameless up and down the streets of other minds where no salutation greets and no sign is given to mark the place one calls one's own.

Whitney M. Young, Jr., to the International Conference of Social Work, Washington, D.C., September 1966.

observations from a visit abroad . . .

YOUTH and YOUTH SERVICES in ENGLAND

KATHERINE B. OETTINGER

Chief, Children's Bureau

British youth today—especially English youth—are not only the fashion models but in many ways also the behavior models of our own young people. Their haircuts (or lack of them), their miniskirts, their motorcycles, their music, many of their freewheeling ways have been adopted with gusto by the teenage generation in this country. Whether much of what our Anglophile youth are avidly importing is actually a reimportation of American exports (as in the realms of music and fashion) may be debated, but what is clear is that the teenagers on both sides of the Atlantic often have more in common with one another than with the adult generations of their own countries.

Therefore, when I visited England shortly before last Christmas, I was particularly eager to learn what the young people there were really like and what special services had been devised to help them meet their problems.

Actually, except for speech differences, including some differences in teenage slang, the English youth seemed very much like their American counterparts. And Carnaby Street, the mecca of the teenage fashion world, seemed no more "far out" than 14th Street or off-main street, U.S.A., except for the studied Edwardian or Regency dress of its salesclerks.

Nowhere apparent among the young people I saw was the once celebrated English reserve; they spoke their minds freely, and boys and girls openly expressed their affection toward one another by walking together hand in hand, arm in arm, or even with arms around each other. This boy-girl behavior, charmingly devoid of self-consciousness, seems to be characteristic of the young people in all the social classes and to be calmly accepted by their elders as a sign that the English have finally got rid of their prudery and are now catching up with their more demonstrative French and Italian neighbors.

The class consciousness of the older generation, I was told, has also almost vanished among the young, due largely to the changes in the educational system that came with the Education Act of 1944 and made ability rather than birth the touchstone for opening opportunities for a high-quality education. But there also seemed to be some feeling that class consciousness has not so much disappeared as changed into consciousness of strata based on educational achievement—the "outsiders" now being those who for one reason or another, not always a lack of native ability, fail the various examinations that open or close the doors to grammar (college preparatory) school, technical school, or the kinds of jobs that lead to something.

Most of the problems worrying adults about the younger generation were familiar to American ears: juvenile delinquency, out-of-wedlock parenthood, sexual promiscuity, functional illiteracy, LSD experimentation, or just a general hedonistic attitude. But there were some differences:

- Unemployment among noncollege educated young people is not the problem in England that it is here. Almost anyone can get a job on leaving school, but many jobs for the unskilled are dead ends just as they are here.
- Proportionately, far more young people in England than in this country leave school at age 16 or under. About two-thirds of the young people in England leave school at age 15—the age that frees them from compulsory school attendance—most of them with an education somewhat comparable to that achieved at the end of junior high school here; while in the United States 72 percent of our young people finish high school. Only 8 percent of the young people in England go on to a degree-giving college or university, as against 38 percent of the young people in this country.
- Homosexuality, though probably not a greater problem in England than here, is certainly more talked about as a problem—increasingly as one requiring sympathetic attention.

These were the problems I heard mentioned most. But I also heard praise for young people's spirit of independence and freedom of expression; their determination not to be "had" by the purveyors of specious values; their des-

perate wish to make something of their lives.

What is there to help them?

Educational opportunities

First there are the opportunities for continued education offered by three types of government-supported colleges: (1) The regional colleges, which are open to all who can pass various examinations and which offer some technical courses and some university preparation; (2) the area colleges, which offer advanced academic programs to the academically eligible and numerous extension courses to others; and (3) the county colleges, which offer a wide range of vocational or life-enriching continuation courses to anyone who wishes to enroll. A great many teenagers in England who are out of school are taking courses of some kind somewhere, in efforts either to pass the door-opening examinations, to satisfy an interest, or to learn a trade. In fact, all young people under 18 who are employed may soon be required to take continuation courses related to their work, and employers may be required to give them time off to do so.

The Youth Service

Then there are the youth clubs, hundreds of them throughout the country, that provide young people with opportunities for bull sessions, social activities, the pursuit of hobbies, community service, and adventure. The prevalence of these clubs represents an interesting combination of government and voluntary efforts on both national and local levels. As in this country, England abounds in voluntary youth-serving organizations—Boy Scouts, Girl Guides, the YMCA, the YWCA, and a variety of sectarian organizations. Along with the local education authorities, these organizations, and their national associations receive grants from the national government for building up programs to provide "association, training, and challenge" to young people under 20, especially those who are no longer in school.

The Youth Service of the Department of Education and Science, through which these grants are made, was first established in 1939 to encourage the coordination of local services for young people and the provision of "new constructive outlets" for their energies. But after the war, it lost out in the competition for public funds so that by the late 1950's both the "constructive outlets" and the supply of persons to lead youth programs were obviously inadequate to meet the needs of a bulging, restless, teenage population. As a result of public concern, in 1958 the Minister of Education appointed a committee, headed by the Countess of Albemarle, to make recommendations on the Youth Service's role in helping young people "play their part in the life of the community" in the light of social change. This committee's report, issued in 1960, has breathed new life into the Youth Service and the programs it supports.[1]

In addition to greatly stepped-up government financial support of the youth services of both the local education authorities and the voluntary organizations, the Albemarle report has resulted in—

- The appointment of a Youth Service Development Council to advise on the 10-year development of the Youth Service through two 5-year plans.
- The construction and improvement of clubhouses for young people, some as wings of modern secondary schools, some as student unions on the grounds of area and county colleges, and some as independent facilities operated by the voluntary organizations. Coffee bars, similar to our teenage canteens, abound, some as come-ons for diversified activity programs available to but not required of the young people who attend.
- The establishment at Leicester of the National College for the Training of Youth Leaders, with scholarships for teachers, social workers, and other mature persons interested in going into full-time youth service work; and the establishment or expansion by voluntary organizations or county colleges of training programs for part-time leaders. Through employers' associations, industrial firms have been asked to give interested employees time off from their jobs to pursue the courses for part-time youth leaders, and some have agreed.
- New experiments in programing with emphases on opportunities for service and adventure. Young people from all socioeconomic levels are working on a volunteer basis with the aged, the mentally retarded, the deaf and mute; they are serving as hospital aides, firefighters, members of mountain rescue teams, members of a motorcycle emergency service. They are also climbing mountains just for fun, exploring caves, going sailing, taking trips abroad.
- Increased efforts to promote greater opportunities for service by young people. Although many young people are engaged in volunteer community services, opportunities for such service are said to be far fewer than potential teenage volunteers. Therefore, a subcommittee of the Youth Service Development Council has proposed the establishment of local and national coordinating bodies, to include young people themselves, to promote interest in service by youth on the part both of young people and the potential users of their service, and to serve as clearinghouses to bring young volunteers and opportunities for service together.[2]
- Efforts to learn more about the activities of "unattached young people"—those who can seem to find no place in society—and help them achieve satisfying group experiences based on their own interests. A 3-year study and demonstration project in this regard, sponsored by the Youth Service Development Council[3] has provoked some controversy because the "detached workers" failed to reveal their purpose to the young people involved.

Youth participation

While there is much of the traditional self-conscious "character building" emphasis in the approach of some youth-serving organizations, I think it is safe to say that the trend in England today is toward recognizing the modern youth's mistrust of anything in which he does not have a hand. Thus young people are being looked to more and more for participation in planning—as in the proposed coordinating bodies for promoting service by youth. And self-programing is the accepted practice in a great many of the youth clubs—particularly those attached to the various kinds of colleges.

The character-building goal is still held by the sponsoring organizations, but it is hidden in an approach that stresses the value of social interaction and mastery of skills in building the necessary base of self-confidence and self-respect. Thus theories of group dynamics, while still hotly debated in some quarters, are being given increas-

ing weight in youth leadership training courses. This emphasis on "social education" is, in fact, the rationale for keeping the Youth Service in the Department of Education and Science, which leans heavily on local educational authorities for developing services, to the consternation of some public welfare workers who regard leisure-time programs as social services and hence a responsibility of the Home Office.

The Albemarle committee's insistence on "challenge" is reflected in the variety of activities demanding the mastery of skill made available to young people through the youth-serving organizations at prices they can afford. And nearly every young person can afford a modest fee, for young people in England today, I was told, have more money in their pockets than any previous generation of teenagers. Participation in skiing, golf, sailing, mountain climbing, or travel no longer identifies a youth as a member of the upper or middle classes.

The emphasis on challenge is perhaps most clearly exemplified by the Duke of Edinburgh's Award Scheme, begun in 1956. Reaching young people not only through the schools and youth-serving organizations but also through a host of industrial firms that sponsor the Scheme for their young factory and office workers, it provides medals for "stickability" and achievement in four leisure-time areas: for boys, service, expedition, pursuits and interests (bird watching, photography, electronics, or whatever), and physical fitness; for girls, "design for living" (homemaking skills), pursuits and interests, adventure, and service. While the Scheme has been criticized for its heavy emphasis on physical prowess, it does include some special programs for the handicapped.

Consultation services

The government responsibility for individual and family welfare in England is lodged in the Home Office, but here again there is a close partnership between governmental and voluntary efforts. The link between the two from the point of view of the person seeking help is the neighborhood Citizens' Advice Bureau, an outgrowth of a wartime emergency service equipped to give anyone who walks in immediate information on where to go to get the kind of help he needs, whether from a government agency, a voluntary organization, or even a commercial enterprise.

Young people whose obvious need is help with a personal problem may be referred to the county council's children's department, which with support from the Home Office offers services comparable to our public child welfare services; to a voluntary family advice service comparable to our family service agencies; or to a voluntary or public mental hygiene clinic. Adolescents in England are, however, as elusive as clients of casework agencies as they are in this country. Therefore, one innovative voluntary service in London, the Young People's Consultation Centre, is worthy of special note.

Dubbed the "worry clinic" by its young patients, this demonstration project is financed through the Youth Studies and Research Foundation by the Bernard Van Leer Foundation of Holland, and was established through the leadership of Mrs. Hilary Halpin. Staffed by psychoanalytically oriented psychologists and social workers, and part-time consultants from other disciplines as needed, it provides a drop-in counseling service to adolescents on their own terms. If the young person does not want to give his address or involve his parents, he does not have to. He can come back for future interviews or not as he chooses. The only question asked of the new patient by the receptionist is whether he wishes a man or woman counselor.

Some young people come to the Centre on referral from schools, social agencies, or employers; many come independently; for the foundation advertised the Centre's services in newspapers, coffee bars, libraries, youth clubs, and subway trains and stations. The response became so overwhelming that the ads were discontinued. The Centre's popularity has continued to grow as news of its services spreads by word of mouth and newspaper advice columns.

The foundation has announced the Centre's services as being for young people between the ages of 15 and 23, but adolescents as young as 12 have turned up and received service. Most of the young people who come to the Centre, however, are 17, 18, or 19. They bring a wide range of problems, some related to immediate crises and calling for simple advice or information, others stemming from longstanding psychological problems of varying depth. Most derive from the gap between the youth's expectation of himself and his experiences in home, school, work, and love.

Personal problems

When advice or information cannot alone help the young person deal with his problem, the Centre's counselor may help him see the relationship between the problem and the emotional difficulties a person normally experiences as he gropes toward maturity. Often this is enough to relieve the strain the young person has been experiencing. For example, a problem frequently brought to the Centre by older adolescents is guilt about past homosexual activities. Most of the young people who come with this problem, however, have already moved beyond homosexual interests and need only to be helped to understand their past behavior as a not unusual manifestation of a phase in human development.

Many young people bring problems stemming from the social change that today accentuates the difference between the generations. For example, a university student told of suffering from constant criticism from his father, a dockhand who could not understand his son's scholarly interests and accused him of being less than a man. The student wanted to leave home, but feared hurting his parents. He was helped to see how he could leave and still maintain a supportive relationship with his family.

Other problems frequently brought to the Centre are worry about extramarital relations, pregnancy out of wedlock, and depression rising from a series of misfortunes—parental indifference, failure at school, a broken love affair. If the young person shows signs of suicidal tendencies, an organization called the Samaritans, which provides 24-hour service, may be called on for help. Pregnant girls are referred to appropriate medical and social resources, but the Centre frequently continues to work with them around the emotional problems that may have led to their difficult situation.

The Centre sees most of the young people who come to it only two or three times. Its original plan was to refer all whose problems were deeply imbedded in their personalities to other

agencies for psychiatric treatment, and many are so referred. However, because of a scarcity of agencies geared to offering this type of help to adolescents, the Centre is now providing some young patients with psychotherapy or psychoanalytic treatment through a panel of cooperating psychotherapists and psychoanalysts.

Another innovation in consultation services to young people is represented by the two Brook Advisory Centres for young people who "want to discuss birth control and sexual or emotional matters." These centers were established largely through the efforts of Mrs. Helen Brook, a board member of the voluntary family planning organization who was distressed by its policy—and the policy of the National Health Services—of refusing contraceptive advice to young unmarried women and girls. The purpose of the centers is to reduce the number of illegal abortions and illegitimate births and to inculcate a sense of sexual responsibility in the young.

The young women who come to these centers—often hand in hand with their young men—are not only given individualized contraceptive service but also an opportunity to discuss the quality of their sexual relationship and the emotional problems surrounding it. The girls return at 3-month intervals for thorough physical examinations and reviews of their total life situation.

Every girl who comes to the Brook Centres receives a pregnancy test, and some come because they fear they are pregnant and know the tests are available. Even if the fear proves unfounded, it is often the opening wedge to helping a girl with emotional problems. When indicated, girls are referred to psychiatrists for treatment or to clergymen for spiritual advice.

Sex education

At what age and by whom sex education should be provided to young people is a matter of debate in England, as it is here. It is, however, offered at some stage and in some manner by most of the "maintained schools"—those operated by the local authorities. There is also some experimenting in this direction by voluntary organizations and church groups. One of these, the Catholic Consultation Service, grew in a few years from a service of direct counseling offered to individual boys by one priest into a widespread network of individual and group consultation services for boys and girls, a leadership training program for teachers in parochial schools, and a training program for parents. According to the Reverend Maurice O'Leary, the founder and director of the organization, schoolteaching nuns are much more responsive to this program than are schoolteaching monks. He believes this is evidence that boys are more neglected than girls in this respect.

Unmarried mothers and delinquents

One out of 14 children born in Great Britain is born out of wedlock [4] (almost the same as the ratio in this country—1 in 15 in 1964). I have no figures as to what proportion of these are born to teenagers, but there is enough concern about schoolgirl pregnancies for a national conference on the subject to have been held in London last year. A concern at that conference was one also demanding increasing attention in this country—how to provide continued education for girls who become pregnant under school-leaving age. Apparently only a few local educational authorities offer opportunities for this.

As in this country, there are in England a variety of public and voluntary services for pregnant girls and unmarried mothers and their children—public assistance, shelter care, maternity care, social casework, and adoption services. At least one organization, the Church Army, is providing counseling to young unmarried fathers. But serious gaps in service still exist, as they do here, particularly in relation to the unmarried mother who keeps her child.

A major problem in England is finding housing accommodations for such fatherless families. Because so few local housing authorities include unmarried mothers and their children on their housing lists, some voluntary agencies are providing special "bedroom-sitting room" residences or "flatlets" for them.

The voluntary organization, the National Council for the Unmarried Mother and Her Child, is comparable to our National Council on Illegitimacy except that, in addition to working for public understanding and better services, the British council provides some direct help to pregnant girls and unmarried mothers and their children. At present, the council is working for better state financial provision for fatherless children and a wider variety of public social services "to compensate them for their disabilities." It is also advocating the establishment of local authority family services supported by the Home Office.

This last recommendation is one evidence of growing interest in building up the social services provided by the local authorities with the goal of strengthening family life—and so strengthening the stability and moral fiber of the young. This is a stated goal in a white paper issued by the Home Office in August 1965 recommending sweeping changes in the handling of juvenile delinquents.[5] It recommends the appointment by each local authority of a family council, composed of representatives of the local children's department and others with a special understanding of children, to make decisions on the treatment of juvenile delinquents under 16, except in cases where the facts are in dispute or the council's recommendations are not complied with. This proposal, needless to say, has met with some criticism from legal quarters.

The white paper also recommends the establishment of courts for young offenders between the ages of 16 and 21—a proposal that has also met with some adverse criticism for taking young people between 16 and 18 out from under the "care, protection, and parole proceedings" provided for by the Children and Young Persons Act of 1963.

Ferment and change

One impression that anyone who makes even the most superficial review of services to young people in England must surely come away with is a sense of ferment and change. I have briefly described some of the developments I learned about on my visit, but even as I describe them they are changing with the needs and moods of the times.

Legislation now before Parliament suggests there may be changes in policies of the National Health Service regarding the physician's role in giving contraceptive advice to unmarried persons.

In 1970, the school-leaving age will be raised to 16, and by then the sharp division between grammar school and secondary modern school, so criticized as the creator of new status distinc-

tions, will no longer hold as the two are merged into the comprehensive schools now being pushed by the Labour Government. By then too the hotly debated proposals for handling juvenile delinquents may have been put into effect or modified. Perhaps too the new voluntary experiments in offering individual and group consultation for troubled young persons, which now seem so limited to London, will have caught on and spread to other areas.

I think it is safe to say that unless there is an unlikely reversal of government support for group programs for youth, both the quantity and variety of opportunities for young people to develop their capacities as social beings will in the next few years greatly increase. Certainly today England more than the United States recognizes government responsibility for supporting young people's development through providing them with opportunities to participate in challenging activities with others. Our Nation has thrown its spotlight on young people who get into trouble with society or who have other serious problems, as well as on the talented young people who are natural leaders. But what about the millions in between?

One thing about the future is clear. Not only England but also here and all over the world there will be even more teenagers than there are now. And *they* will have new ideas and wills of their own. And the adults there, here, and everywhere will be hard put to keep up with them.

[1] Ministry of Education: The youth services in England and Wales. Report of the committee appointed by the Minister of Education in November 1958. Her Majesty's Stationery Office, London. 1960. (Reprinted 1964.)

[2] Department of Education and Science: Service by youth. Report of a committee of the Youth Service Development Council, December 1965. Her Majesty's Stationery Office, London. 1966.

[3] Morse, Mary: The unattached: a report of the 3-year project carried out by the National Association of Youth Clubs. Pelican Book A–737. Penguin Books, Harmondsworth, England. 1965.

[4] The National Council for the Unmarried Mother and Her Child: Annual report, April 1965–March 1966. London.

[5] Home Office: The child, the family, and the young offender. Her Majesty's Stationery Office, London. August 1965. (Reprinted 1966.)

guides and reports

MARSHALLING COMMUNITY SERVICES ON BEHALF OF THE ABUSED CHILD. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 80201. 1966. 30 pp. 35 cents.

Three papers given at the 1966 meeting of the National Conference on Social Welfare. The first analyzes State laws for reporting child abuse; the other two report on the implementation of reporting laws in a State-administered child welfare program and in a county-administered program.

WELFARE AND WISDOM: lectures delivered on the fiftieth anniversary of the School of Social Work of the University of Toronto. Edited by John S. Morgan. University of Toronto Press, Toronto, Canada. 1966. 184 pp. $5.

Contains eight lectures on welfare in relation to social, economic, and political development by four scholars: T. H. Marshall, professor emeritus of sociology, University of London; Eugen Pusić, professor of public administration, University of Zagreb; Malcolm Adiseshiah, economist from India and deputy director-general of UNESCO; and Charles Frankel, U.S. Assistant Secretary of State for Educational and Cultural Affairs.

PSYCHOPATHOLOGICAL DISORDERS IN CHILDHOOD: theoretical considerations and a proposed classification. Committee on Child Psychiatry, Group for the Advancement of Psychiatry, 104 East 25th Street, New York, N.Y. 10010. 1966. 343 pp. $3.50. Discount on orders of 10 or more.

Proposes a classification of the mental and emotional disorders of children and adolescents from a framework embracing the psychosomatic, developmental, and psychosocial points of view and taking into account the differences between the psychopathologies of children and those of adults.

PUBLIC WELFARE PROJECTED. American Public Welfare Association, 1313 East 60th Street, Chicago, Ill. 60637. July 1966. 206 pp. $2.75.

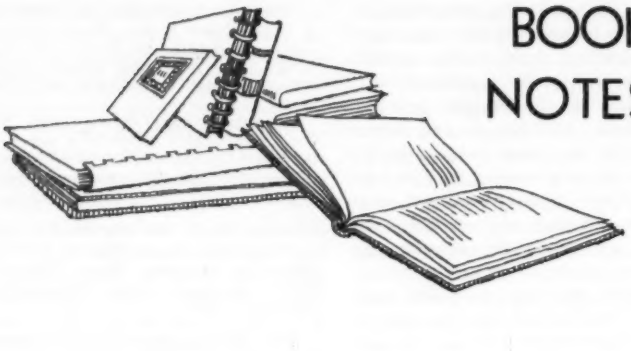
Contains 23 papers from the 1965 biennial conference of the American Public Welfare Association, including papers on the future shape and goals of public welfare programs and problems of educating and deploying staff.

MANPOWER IN SOCIAL WELFARE: research perspectives. Report of the Institute on Research Approaches to Manpower Problems in Social Welfare Services to Children and Families, held at the University of Minnesota, August 23–26, 1964, with support from the Children's Bureau. Edward E. Schwartz, editor, National Association of Social Workers, 2 Park Avenue, New York, N.Y. 10016. 1966. 160 pp. $3.

The 10 institute papers, grouped under 4 headings—trends and projections, the welfare system, the professional system, and career choice and education—are followed by a condensation of the discussion under the title, "A Strategy of Research on the Manpower Problem."

THE COMSTAC REPORT: standards for strengthened services. Edited by Frances A. Koestler. Commission on Standards and Accreditation of Services for the Blind, 15 West 16th Street, New York, N.Y. 10011. 1966. 393 pp. $3, paperback; $6 clothbound.

Contains recommended standards for administration and service programs for agencies serving blind and visually handicapped persons.



BOOK NOTES

COMPENSATORY EDUCATION FOR THE DISADVANTAGED: programs and practices: preschool through college. Edmund W. Gordon and Doxey A. Wilkerson. College Entrance Examination Board, Princeton, N.J. 1966. 299 pp. $4.50.

A comprehensive report on Federal, State, and local programs in compensatory education for disadvantaged children, this book surveys dozens of projects, including Project Headstart and Upward Bound, and comments on some aspects of their probable effectiveness. For example, one chapter reports on a survey of compensatory programs in progress at colleges and universities; another describes programs in progress at all levels of education. The book concludes with a directory of compensatory practices and a listing of programs by State and region.

In evaluating the programs, the authors, both on the faculty of Yeshiva University, maintain that teaching disadvantaged children is a special task and cannot be left "to the newest teachers . . . nor to the older teachers, 'left over' in the center-city schools. . . ." They also maintain that many of the programs they surveyed were designed without systematic study of ends and means, despite the seriousness of the problems of educating children and young people from disadvantaged backgrounds.

THE DISADVANTAGED CHILD: issues and innovations. Edited by Joe L. Frost and Glenn R. Hawkes. Houghton Mifflin Company, Boston, Mass. 1966. 445 pp. $4.95.

The characteristics of deprived children and of the education they receive are the central theme of the 37 articles carried in this book. For the most part reprints from periodicals and other publications, the articles are presented under eight heads: who the disadvantaged are; characteristics of the disadvantaged; intelligence and IQ; education and the young child; education and the older child; teaching communicative and problem-solving skills; training teachers of the disadvantaged; and the individual, family, and community. The book concludes with a bibliography of books, monographs, periodicals, and research studies on the subject of educating the disadvantaged child.

Contributors include Robert J. Havighurst, Frank Riessman, Jerome S. Brunner, Martin Deutsch, and Helen Heffernan.

LEARNING AND ITS DISORDERS: clinical approaches to problems of childhood, volume 1. Edited by I. N. Berlin, M.D., and S. A. Szurek, M.D. Science and Behavior Books, Inc., Palo Alto, Calif. 1966. 295 pp. $5.95.

The two psychiatrists who are the editors of this collection of 28 papers on learning and its disorders have brought together material they report they have found useful in teaching. Dr. Berlin is the author of 12 of the papers; Dr. Szurek, of one, and the coauthor of another. The papers are grouped under six general subjects: the beginning of learning and its distortions; the teacher's role and problems; community psychiatry and the schools; antisocial behavior as failure and distortion in learning; learning as a therapeutic tool in antidelinquency projects; and therapeutic efforts in learning disturbances.

In his introduction to the collection, Fritz Redl says: "The editors . . . are among the few people thoroughly grounded in psychiatric lore, exceptionally experienced in clinical practice, and at the same time respectful of and conversant with the real life problems of both the child learner and the classroom teacher. It is this aspect which makes the volume unique."

CONSTANCY AND IQ CHANGE: a clinical view of relationships between tested intelligence and personality. Alice E. Moriarity, Charles C Thomas, Springfield, Ill. 1966. 223 pp. $8.50.

IQ test scores from infancy to prepuberty may reflect "dynamic interactions between an individual child and his environment," according to this book written by an associate of the Menninger Foundation. She bases her conclusion on a study of 65 children of normal intelligence who were tested and whose behavior was observed over a period of 12 years during four phases of their lives—infancy, preschool age, latency, and prepuberty.

The changes in 18 scores indicated that intellectual functioning developed in the children in four ways—constantly, by accelerated spurts, slowly, or erratically—the author reports. Constant development characterized children who were inclined to restrict themselves; acceleration by spurts, children with high achievement drives; slowness, children who were emotionally dependent; and fluctuating development, children highly vulnerable to the stress of environment.

The author concludes that such an analysis of constancy and change in the IQ's of children could "broaden the usefulness of tests" and could throw "new light on the old controversy about constancy of IQ."

DEMON IN MY VIEW. Arthur Henley. Trident Press, New York. 1966. 181 pp. $4.95.

Following a semibiographical method, this book describes the work of Adelio Giuseppe Ambruano Pasquale Antonio Montanari—better known as Monty—the founder-director of a residential treatment center for highly disturbed children in Florida used from time to time by private and public agencies alike. The author points out that many of the children the center has treated successfully seemed to be hope-

less cases—for example, a girl who thought she was a dog, a boy who could not resist stealing Cadillacs, and a girl who thought a man was speaking in her head.

In the center, the author reports, a group of psychiatrists, psychologists, and social workers sets up the diagnostic and treatment plan for each child, pivoted on individual treatment. He attributes much of the center's success to the strong, personal involvement of the founder-director and his willingness and that of his staff to use unorthodox methods when necessary.

DYNAMICS OF DEVELOPMENT: euthenic pediatrics. Dorothy V. Whipple, M.D. McGraw-Hill Book Co., New York. 1966. 648 pp. $15.

This volume offers pediatricians and other professional men and women working with children "a philosophic background and a point of view for understanding what makes children tick," rather than a practical guide to pediatrics, according to its author, a clinical associate professor of pediatrics at Georgetown University School of Medicine.

With an emphasis on well-child supervision, the book discusses both the physical psychological aspects of growth and development in children from heredity and intrauterine life through adolescence. Its chapters are grouped under the following topics: The scope of pediatrics; the beginnings; the increment in pounds and inches; the development of organic structure; life patterns of sleep and nutrition; the development of behavior; horizontal pictures; and sociological considerations in relation to the family.

JUVENILE DELINQUENCY: a book of readings. Rose Giallombardo, editor. John Wiley & Sons, New York, 1966. 565 pp. $8.95.

This textbook, according to the editor, "is designed to introduce the student of juvenile delinquency to . . . important contemporary literature in the field." It contains selections from journals, books, and monographs that treat juvenile delinquency from a sociological viewpoint, either by reporting the results of research or by providing theoretical analyses and description. The readings are grouped under five sections: The data of delinquency; problems of definition and measurement; development of delinquent behavior; the empirical structure of delinquent groups; legal processing of delinquency; and treatment and prevention.

STUDIES OF TROUBLESOME CHILDREN. D. H. Stott. Humanities Press, New York. 1966. 208 pp. $5.50.

Deviant behavior in children may be caused by a greater than normal susceptibility to stress because of "congenital impairment" (the result of something that happened before or at birth) rather than by an unfavorable environment, the author of this book maintains. In evidence, he describes several studies of disturbed children made in Great Britain, including one on 300 truants, that points to a "consistent congenital factor" beneath deviant behavior.

Congenital damage tends to cumulate, the author also maintains. The child who suffers from "one form of somatic-neural impairment" is likely to suffer from a second; if from two, than from a third, and "so on . . . until the point of nonviability is reached," he points out in an hypothesis he calls the "law of multiple congenital impairment."

In discussing the "law" in relation to diagnosis, prevention, and treatment, the author says that it applies particularly to the selection of children prone to delinquency and to treatment for them by casework.

The author also describes a program to prevent maladjustment to school, which he has designed on the basis of a mental health service for children.

In his final chapter, the author explains his general view of human motivation, on which his law of multiple congenital impairment is based.

HOMEMAKING FOR THE HANDICAPPED: a resource book in home management for the physically handicapped and their families and for professional personnel concerned with rehabilitation. Elizabeth Eckhardt May, Neva R. Waggoner, and Eleanor M. Boettke. Dodd, Mead & Co., New York. 1966. 206 pp. $7.50.

Although 12 percent of the more than 40 million Americans (mostly women) who keep house are physically handicapped, homemaking "continues to be the most neglected area of rehabilitation," according to the authors of this book, which aims at supplying a guide to the handicapped homemaker, her family, and the rehabilitation worker.

The book explores management principles used by women with physical disabilities; ways to simplify tasks in the care of children and play activities handicapped mothers can supervise; selection and adaptation of clothing for handicapped persons; devices, tools, and methods that save energy and time; and the adaptation of equipment for child care and housekeeping.

INSTITUTIONS ARE PEOPLE: a documentary of life in a State school for the mentally retarded. E. Charles Bauer. The John Day Co., New York. 1966. 156 pp. $4.50.

By describing his work as a chaplain for 7 years at a State school for the mentally retarded, the author of this book gives a picture of life in an institution for patients and staff members alike. Though puzzled at first by what he could do to serve the patients, in time he learned to "help fight the war against mental retardation as a member of the training and treatment team." He points out that, although there is much room for improvement, the institution at which he served is operated by many devoted and skillful people.

TEACHING DISADVANTAGED CHILDREN IN THE PRESCHOOL. Carl Bereiter and Siegfried Engelmann. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1966. 312 pp. $7.95.

To help the disadvantaged child enter first grade on a footing with other children, the authors of this book have devised a program based on the assumption that preschool education must meet definite, day-to-day goals and that direct control over the pupil's progress is necessary. Much of this book is given to a description of their plan.

Because they believe that cultural deprivation stems largely from language deprivation, the authors point out that their plan centers on strongly structured courses in language. By overcoming language handicaps, they maintain, the disadvantaged child can overcome many other handicaps. In support of their method, the authors summarize the results of an experiment they conducted

using it with a group of severely deprived 4-year-old children who were brought up to the second-grade level in arithmetic and to the first-grade level in reading in 9 months' time.

CHILDREN IN CARE—AND AFTER: a study of a group of Glasgow children who came into the care of the local authority. Thomas Ferguson. Oxford University Press, New York. 1966. 139 pp. $2.40.

Four out of 5 of over 200 young people who had been brought into public care and "boarded out" with foster parents, placed with relatives (not parents), or placed in a children's home were found to have reasonably good prospects 2 years after they had "passed out" of care at 18, according to this report on a study made recently in Scotland.

The author reports that at the time of the study these young people were employed at about the same rate as other young people in the general population but that the jobs they held usually required less skill. However, he also found that based on IQ scores these young people performed at about the same level as young people from normal homes who left school at the earliest age permitted.

He also reports that about 5 percent of the young men have been convicted of breaking the law and that about 11 percent of the young women have had children out of wedlock (several before reaching 18), a slightly higher percent on both counts than in the general population. On the whole, he found them immature, particularly socially.

EMERGING CONCEPTUAL FRAMEWORKS IN FAMILY ANALYSIS. Edited by F. Ivan Nye and Felix M. Berardo. The Macmillan Co., New York. 1966. 328 pp. $7.95.

This book deals with theories about the family and approaches to research on the family. The 11 papers that comprise it consider the family from the point of view of anthropology; structure and function; institutional, interactional, and situational approaches; psychoanalysis; social psychology; developmental theory; economics; law; and religion and philosophy.

films on child life

Charges for rental or purchase may be obtained from distributors.

"M.R." 60 minutes; sound; color; rent or purchase.

Depicts the interacting roles of many professional and nonprofessional persons in behalf of retarded children, including the contribution of physicians and others in a State crippled children's program.

Audience: Professional and lay persons concerned with mental retardation.

Produced by: Bureau for Handicapped Children, Wisconsin State Department of Public Information; and the University of Wisconsin.

Distributed by: Bureau of Audio-Visual Instruction, University of Wisconsin, 1312 West Johnson Street, Madison, Wis. 53702.

HER NAME WAS ELLIE, HIS NAME WAS LYLE. 29 minutes; sound; black and white; purchase.

Tells the story of a high school boy infected with syphilis who is unaware of the services available for treatment. Stressing both the physical and emotional consequences of promiscuity, it describes the infectious nature and points out the importance of early treatment. It also portrays the role of the physician and public health department in treating venereal disease and in tracking down the sources of infection.

Audience: Youth groups and junior and senior high school students, with a physician, nurse, or other trained discussant.

Produced by: Louis DeRochemont Associates, for the Bureau of Public Health Education, New York City Department of Health.

Distributed by: Louis DeRochemont Associates, 18 East 48th Street, New York, N.Y. 10017.

BOY TO MAN. 16 minutes; GIRL TO WOMAN. 18 minutes; sound; color; purchase.

Stressing the normality of individual differences in the rates of physical growth and sexual maturation between boys of the same age and girls of the same age, these films explain simply the physiological manifestations of maturation in adolescent boys; the male and female reproductive functions, and the relation of secondary sexual changes to glandular and primary sexual changes. They employ basic scientific terms, which are enunciated and also presented in written form on the screen.

Audience: Junior high school boys and girls; parents; and science, physical education, and health education instructors.

Produced by: Churchill-Wexler Films.

Distributed by: Henk Newenhouse, Inc., 614 Davis Street, Evanston, Ill. 60201.

THE LOSERS. 31 minutes; sound; black and white; rent or purchase.

Aimed at making young people more aware of the damage caused by the use of drugs, this film looks into an investigation of the prevalence of experimentation and the habitual use of pep pills, goof balls, heroin, and marijuana and the practice of glue-sniffing among young people 12 to 21 years of age. The harmful effects of such practices are shown, and recounts of actual experiences by young people from slums and middle-class neighborhoods are presented.

Audience: Youth classes in health education; teachers; guidance counselors; doctors; psychologists; sociologists; and PTA groups.

Produced by: WCBS-TV, New York.

Distributed by: Carousel Films, Inc., 1501 Broadway, New York, N.Y. 10086.

HERE and THERE

Child labor

Between July 1, 1965, and June 30, 1966, nearly 18,500 children were employed in violation of the child labor provisions of the Fair Labor Standards Act, according to figures compiled by the U.S. Department of Labor, Wage and Hour Public Contracts Division. The law prohibits the employment in interstate commerce or in the production of goods for interstate commerce of children under 16 years of age during school hours, of children under 18 in hazardous occupations at any time, and of children under 14 in any occupation at any time. While minors 14 and 15 years of age may be employed outside school hours in nonmanufacturing and nonmining occupations, regulations regarding hours of work and other specific conditions must be complied with.

The law also prohibits the employment of children under 16 in interstate agriculture during school hours, except by their own parents on home farms. (Before February 1, 1967, the minimum age for such employment was 14.) However, children of any age may work in agriculture outside school hours unless they are in occupations declared hazardous by the Secretary of Labor.

Violations of the act were found in 1,725 of the 2,880 farms investigated by the Department. Nearly 5,500 of the children whose employment was in violation of the act were children under 16 working in agriculture during school hours. About 18 percent were 9 years old or younger; about 52 percent were 10 through 13. The total includes nearly 1,300 migrant children.

Over half of the 12,979 children employed in violation of the law in nonagricultural occupations were in hazardous occupations, most often as drivers of or helpers on motor vehicles. Some were employed in violation of more than one of the 17 hazardous occupations orders issued by the Secretary of Labor. Approximately 41 percent of the minors found illegally employed in nonagricultural occupations were under 16 years of age. Children ranging in age from 5 to 15 years were employed often in occupations so hazardous that an 18-year minimum age applied, or were working excessive hours or in manufacturing occupations.

Refugee children

As of December 31, 1966, only 395 Cuban refugee children were still in foster care under the United States Cuban refugee program, the lowest number since the initiation of the program in 1961 (see "Cuban Children Away From Home," by Kathryn Close, CHILDREN, January-February 1963). Thus, more than 8,200 of the 8,600 Cuban children who have arrived in this country without their parents or designated guardian in the past 6 years have been reunited with their parents in this country or elsewhere or have passed the age of 19 and are no longer eligible for care under the program. Of these, 1,032 were discharged from the program during 1966 to newly arrived parents, most of whom came from Cuba by the United States Cuban refugee airlift. The airlift, which began in December 1965, operates 10 planes a week from Cuba to Miami.

For youth

The need for early planning of summer programs for adolescents was underscored in an all-day meeting held in Washington, D.C., on January 18 under the sponsorship of the Children's Bureau. The 32 participants represented 21 national voluntary organizations and 5 units of the Federal Government. The purpose was to find ways in which the Federal Government and the voluntary agencies could work together to provide young people with opportunities for satisfying and creative leisure-time activities during their summer vacations.

The participants reported that the stimulus of the Federal Government's interest in 1966—sparked by a task force created by the President—had indeed resulted in many more, and a great diversity of, opportunities being provided young people during that summer than in the previous summer. Their agencies had, for example, not only expanded their regular camping, sports, and club programs, but had also provided many new opportunities for young people to have adventure, to serve their communities, and to explore possible careers. However, they frankly discussed some of the obstacles to the maximum use of resources they had encountered and most frequently named late planning and fragmentation of effort. Representatives of voluntary agencies especially stressed the importance to achieving greater effectiveness in 1967 of their knowing well in advance of the summer what would be expected of them and what financial resources would be available to them through what government agencies.

The Children's Bureau accepted responsibility for finding out what summer projects are being planned by other Federal agencies and for keeping the national voluntary agencies informed as plans develop.

Sex education

Approximately 75 professional people met together in Washington, D.C., for 2½ days in early December at the invitation of the Sex Information and Education Council of the United States (SIECUS) to discuss and plan for the education of young people and adults in matters of sex. The conference was made possible by a grant from the Office of Education.

The focus of the conference was on the preparation of an interdisciplinary book of readings on sex education for teachers in training, but the discussions ranged far beyond the bounds of this topic.

Most of the working groups stressed

the necessity of helping society at large as well as young people acquire social values and a philosophy about sex that can serve both society and the individual. The discussions underscored the importance to the community of sex education for young people and the responsibility of many social institutions for providing it.

Parent education was considered as central to any and all sex education that takes place in the home. Participants maintained that the most fundamental element in the sex education of children is the relationship between parents, and that parents, therefore, need to know what their own values are and to be able to convey them to their children in the course of day-to-day living. The responsibility of the school from preschool through high school was emphasized. Major obstacles to meeting this responsibility were identified as a dirth of educational materials and a scarcity of teachers to carry out sex education adequately.

The need for more research was also stressed, especially in relation to the current sexual behavior of adolescents and young adults.

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Among the opportunities for leadership training in sex education being offered in the summer of 1967 are the following:

• A 6-week institute, June 26–August 4, at the University of Connecticut entitled, "The Family Life Institute With Emphasis on Sex Education," and directed to persons at the graduate level of study. Sponsored by the university's department of child development and family relations with the help of the G. D. Searle Reference and Resource Program, it will be conducted by specialists in family life education from both inside and outside the university. The fee for the institute is $95; enrollment is limited to 60. For further information inquire of Eleanore B. Luckey, Department of Child Development and Family Relations, University of Connecticut, Storrs, Conn. 06268.

• A 1-week workshop at the University of Oregon, June 12–17, for 40 adults—teachers in secondary schools, guidance counselors, social workers—and 40 young persons of teen age, sponsored by the department of health education. The fee for the adults is $28. The young people, who are to be recruited from local high schools to represent a kind of "laboratory" for the adults, will be provided scholarships. Inquire of Robert E. Kime, Department of Health Education, University of Oregon, Eugene, Oreg. 97403.

• Two 1-week institutes, June 19–30 and August 7–11, at the University of California at Davis, sponsored by the extension division, the first for both adults and young people (30 each) as in the Oregon institute, the second for teachers of family living courses. The fee is about $45. Inquire of Lura Middleton, Extension Division, University of California, Davis, Calif. 95616.

Child abuse

Warnings against "abusing the parents" of children who are victims of parental abuse and so aggravating the abuse of the child were repeatedly given in the Governor's Conference on Child Abuse held in Raleigh, N.C., November 22, 1966. Called by the Governor to focus public attention on the problem of child abuse, the conference was sponsored by the North Carolina Health Council; the North Carolina Council on Mental Retardation; the State Department of Public Instruction, Public Welfare, and Mental Health; and the State Board of Health. It was made possible by a grant from the Alfred I. DuPont Institute of the Nemours Foundation. The more than 650 participants included physicians, social workers, health workers, police officials, juvenile court officials, school administrators, and teachers.

Speakers at the conference discussed the social, medical, and cultural aspects of child abuse and the roles of social work, medicine, the courts, and education in meeting the problem. They emphasized the need for skillful people to handle the problem.

Proceedings of the conference are available from the North Carolina State Board of Health, Maternal and Child Health Section, Raleigh, N.C. 27602.

Toward coordination

The Department of Health, Education, and Welfare (DHEW) recently set up a new center for community planning in the Office of the Secretary to work closely with the Department of Housing and Urban Development (DHUD) on programs aimed at solving the problems of cities. Besides acting as the liaison office with DHUD for DHEW, the center reviews proposals for model city projects and provides technical assistance to DHUD on the needs of cities in relation to health, education, and welfare. The center also coordinates the activities of DHEW constituent agencies concerning model city projects in providing technical planning services to city and State governments and local agencies.

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The American Public Welfare Association (APWA) is launching a 3-year project under a grant from the Office of Economic Opportunity (OEO) to provide technical assistance to public welfare departments and local community action programs to stimulate a relationship between them for the purpose of strengthening public welfare programs.

Still in the explorative stage, the project has a tentative list of priorities for consideration with public welfare officials. These include: (1) Development of "structured" services focusing on specified purpose, product, or results; (2) methods of communicating with public assistance recipients and with the organized poor; (3) aspects of administration of financial aid affecting equity and incentive; (4) opportunities for employment and achievement of the poor in the public welfare establishment; (5) the role of the poor and community action groups in public welfare policymaking and planning; and (6) the role of public welfare agencies in developing better housing.

The project will operate under the direction of a small headquarters staff and advisory committee. Its director is John M. Wedemeyer, formerly director of the California State Department of Social Welfare.

Unmarried mothers

As part of the Children's Bureau maternal and infant care project in Chicago, the Florence Crittenton Association of America, Inc., has recently established the Crittenton Comprehensive Care Center to administer the expanded program of comprehensive medical, mental health, and social services project for adolescent unmarried mothers and fathers that grew out of the Community Services Project, a 3-year demonstration project initiated by

the mental health division of the Chicago Board of Health. (See "Comprehensive Services for Adolescent Unwed Mothers," by Mattie K. Wright, CHILDREN, September–October 1966.) Operating under an agreement between the Chicago Board of Health, the Illinois State Department of Public Health, and the Florence Crittenton Association of America, Inc., with the Children's Bureau's financial support, the center is building up a staff of health educators, psychologists, social workers, nurses, nutritionists, obstetricians, and other health specialists. It is expected to serve from 1,200 to 1,500 adolescent unmarried mothers and their families annually, including, whenever possible, the fathers of their children. Mrs. Wright, former director of the Community Services Project, is its director.

The new center works closely with the Chicago Board of Education and refers pregnant girls who are willing and able to continue their schooling to the board's family living center, established last fall to make this possible.

Research on children

Seven research studies in child development and child welfare have been initiated in Great Britain by the National Bureau for Co-operation in Child-Care since its formation 3 years ago by British voluntary organizations and professional associations concerned with the welfare of children.

The bureau has a fourfold purpose: To make existing knowledge of children's development, needs, and problems more readily available; to improve lines of communication between the disciplines and the statutory and voluntary services; to explore the possibilities of making better use of existing services and to encourage the development of new ones; and to help bring a preventive outlook into the field of child care. It works through a staff headed by psychologist M. L. Kellmer Pringle, which carries out the research projects, and through local and area "groups"—open to persons engaged in health, education, or welfare services to children—which meet regularly to discuss the needs of children.

Through an arrangement with a commercial publisher (Longmans, London), the first three of the bureau's research reports were published in 1966: "Four Years On," a followup study at age 15 of children whose development had been followed between the ages of 7 and 11 when they were attending two different types of junior schools—traditional and progressive; "11,000 Seven-Year-Olds," the first report of a longitudinal study of children born in 1958 concerned with their abilities, progress, behavior, and health in relation to environmental factors; and "Adoption—Facts and Fallacies," a review of research relating to adoption in the United States, Canada, and Great Britain between 1948 and 1965.

Other studies still in progress are a longitudinal study of junior school children, a pilot study of family advice services, a national study of children in foster care, a national study of "word-blind" children, and a study of educational and employment opportunities for young people with multiple handicaps.

Child care

Intensive casework with children in foster care and instruction in homemaking for families helped end or prevent the need for foster care for many of the more than 400 children served by a 3-year, two-part project operated by the Santa Clara County Welfare Department in California between 1962 and 1965, for families receiving assistance under the aid to families with de-

PRESIDENT'S MESSAGE ON THE WELFARE OF CHILDREN

Pointing out that as long ago as 1912 when the Federal Children's Bureau was established "Congress had pledged its power to the care and protection of America's young people," President Lyndon B. Johnson sent the Congress a Message on the Welfare of Children on February 8, 1967 embodying a 12-point program for broadening the Nation's activities for the health and welfare of children. In his message, the President referred to studies which indicate that ignorance, ill health, and personality disorder are "disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation." Maintaining that "our goal must be clear—to give every child the chance to fulfill his promise," the President recommended measures to—

"1. Preserve the hope and opportunity of Headstart by a 'Follow-Through' program in the early grades.

"2. Strengthen Headstart by extending its reach to younger children.

"3. Begin a pilot lunch program to reach preschool children who now lack proper nourishment.

"4. Create child and parent centers in areas of acute poverty to provide modern and comprehensive family and child development services.

"5. Help the States train specialists—now in critically short supply—to deal with problems of children and youth.

"6. Strengthen and modernize programs providing aid for children in poor families.

"7. Increase social security payments for 3 million children, whose support has been cut off by the death, disability, or retirement of their parents.

"8. Expand our programs for early diagnosis and treatment of children with handicaps.

"9. Carry forward our attack on mental retardation, which afflicts more than 125,000 children each year.

"10. Launch a new pilot program of dental care for children.

"11. Help States and communities across the Nation plan and operate programs to prevent juvenile delinquents from becoming adult delinquents.

"12. Enrich the summer months for needy boys and girls."

pendent children program, according to the project's report. Through the project, the county welfare department offered intensive casework to families of 137 children in foster care and instruction in child rearing, money and household management, health care, and parent-child relationships to 59 families with 299 children. All families either had children in foster care or were faced with the possibility of placing a child in foster care. Most had only one parent.

In drawing their conclusions, project workers pointed out that nearly half of the 137 children for whom intensive casework services had been provided had been taken out of foster care by the end of the project. Twenty-nine had been reunited with their parents, 38 had been adopted, and 4 were awaiting adoption. The service was provided by professionally trained caseworkers with special skill in working with children and their families.

Only 13 children of the 59 families involved in the homemaker part of the project were in foster care at the end of the 3 years.

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The Utah State Department of Welfare recently authorized the 20 nonprofit day-care and training centers for retarded and handicapped children receiving State financial support to add trained social workers to their staffs and agreed to pay 80 percent of the workers' salaries. Three centers have already employed social workers.

The centers are located in urban and rural areas throughout the State. The first was set up in 1956 by the parents of the children who were later enrolled, professional men and women, and others interested in the welfare of mentally retarded and handicapped children. In 1959 the State began giving support to the centers, at first through demonstration grants. The centers are now supported by tuition fees, community contributions, and State funds. The 20th center opened last January.

Education

Early in January the Office of Education issued its desegregation guidelines to the States for the school year 1967–68. In an accompanying letter, Commissioner of Education Harold E. Howe pointed out that these are virtually the same as those issued for 1966–67. The one substantive change affects only school districts operating under a "freedom of choice plan." In the school year 1967–68, these districts will have more time in which to choose the 30-day period during which students may designate the schools they prefer to attend.

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To alert high school students who will graduate this year to the Federal programs of financial assistance offered to college and vocational school students, the Office of Education early this year sent out a packet of material on such programs to every high school, college financial aid office, and library in the Nation, to American schools overseas, and to persons working with young people such as the directors of Upward Bound programs.

Single copies of the packet are available from the Bureau of Higher Education, Office of Education, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20202.

Family planning

The New York State Department of Social Welfare recently ruled that caseworkers employed by local public welfare departments may introduce the subject of birth control to persons in their caseloads, when advisable. The department had previously ruled that caseworkers could not bring up the subject, though they could furnish information about where to go for contraceptive service if the client requested it. Under the new ruling, women who show interest in birth control after being advised that such a service is available will be referred to an appropriate health agency. The welfare department will continue to pay for materials and medications as "directed or prescribed with reference to family planning" for clients of welfare departments.

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Anticipating a recommendation by the population study commission appointed by the Governor of California in August 1966, the California State Department of Public Health, at the request of the California Conference of Local Health Officers, adopted a regulation on December 2, 1966, making the provision of family planning services by local health departments a requirement for eligibility for State subsidy. The commission, which had been appointed to review and prescribe State and local activities "to increase freedom of choice in family planning," submitted its report on December 20. Among other recommendations, it urged that—

- Family planning services be provided in a way that would insure comprehensiveness in personal health care.
- Family planning services include genetic counseling and fertility service in addition to contraceptive advice and service.
- Welfare departments assume responsibility for assisting clients in acquiring a better understanding of the problems related to family size and for referring those interested in family planning to appropriate services.
- Information about family planning be included in welfare department in-service training programs.
- Information about family planning services be included in the referral services of the State's multiservice centers.
- Medical education include content about genetic counseling, the effect of family composition on health, and methods of family planning.
- A public information program be developed to promote the idea that every child should be a "wanted" child.

Miscellaneous

On January 1, 1967, the former International Conference on Social Work (ICSW) became the International Council on Social Welfare, with a revised constitution and its first full-time secretariat. Ruth M. Williams, who was director of the New York office of the National Conference on Social Welfare and half-time executive officer of the International Conference for 16 years, has become the first full-time secretary general of the Council. Headquarters for ICSW remain at the old address—345 East 46th Street, New York, N.Y. 10017.

The revised constitution for ICSW identifies four principal functions: (1) To provide a worldwide forum for the discussion of issues in social welfare; (2) to foster the development of social welfare throughout the world; (3) to promote the exchange of information among social workers and social agencies; and (4) to promote cooperation among international organizations concerned with social welfare.

READERS' EXCHANGE

AMBINDER and FALIK: *Collaborative consultation*

In their article "Keeping Emotionally Disturbed Foster Children in School" (CHILDREN, November–December 1966), Walter J. Ambinder and Louis H. Falik of the Detroit Foster Homes Project graphically illustrated not only natural difficulties encountered by a foster care agency when it attempts to intervene in a public school's methods of dealing with a foster child, but also certain problems that might have been modified or avoided under a mode of operation sensitive to the structure of public school organization.

When a mental health agency attempts such intervention in behalf of *any* emotionally disturbed child, often it does not seem aware of certain facts: (1) That authority in public schools proceeds in a direct line from superintendent to principal to classroom teacher; (2) that school systems need a variety of educational settings so that in placing a disturbed child in public school the limits of a particular school to tolerate his behavior may be assessed in relation to the training and the personality of the teacher, the number of pupils in each class, or the availability of special classes; (3) that each case needs a realistic estimate of the potential of the disturbed child to function "in a normal school setting" based on such factors as his tolerance to frustration, his degree of impulse control, and the nature of his aggressive drives; (4) that a severely disturbed child sometimes needs a brief period of complete release from school demands, followed by school attendance in brief but gradually lengthened sessions.

Over the past 3 years, the Merrifield Center project in Worcester, Mass., with support from the National Institute of Mental Health, has provided residential treatment for severely emotionally disturbed children in foster care. In working with public schools, the center's staff has sought to promote *collaborative consultation* with the school to keep severely disturbed children in regular classes in public schools. This involves a continuous interpersonal process based on the following conditions: (1) Recognition by both school and agency of the differential roles of educators and clinicians; (2) development of attitudes of mutual trust and respect so that a workable atmosphere is established in which representatives of diverse disciplines can discuss learning and behavior difficulties of disturbed children; (3) continuing efforts by agency personnel to maintain rapport with educators even when the latter exhibit defensive behavior, ambivalence, or resistance; (4) retention by the school of independence in decisionmaking in regard to school matters; and (5) assumption by the agency of responsibility to interpret school decisions to the foster parents.

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EISENSTEIN: *An oversight*

I note with interest the four objectives of the health program discussed by Fannie Eisenstein in the November–December 1966 issue of CHILDREN ("A Health Service Program for Children in Day Care") and wonder how she could overlook as important an aspect of child health as good hearing. She does not mention any planning to include a check of the children's hearing or parent guidance to prevent hearing loss.

More lives are handicapped by poor hearing than by almost any other physical disability. National statistics indicate that about 7 percent of children entering school have hearing trouble. Of these, over half can be successfully treated by medical procedures. Three percent of these children have permanent hearing impairments, many of which could have been prevented.

Any health program for preschool-age children is seriously inadequate if emphasis is not put on hearing examinations and prevention of hearing loss.

C. E. Torrence
Director of Hearing and Speech Services, St. Louis Hearing and Speech Center, St. Louis, Mo.

Author's reply

The point Mr. Torrence makes about hearing is well taken. We attempted to locate screening and preventive programs and found none available for a universal, group application. We, therefore, were limited to the ongoing observation of teachers, parent education, and the agonizing search for direct service on an individual basis in an area which lacked both programs and persons qualified to provide the needed service.

Fannie Eisenstein

for parents

TODAY'S TEENAGERS. Evelyn Millis Duvall. Association Press, 291 Broadway, New York, N.Y. 10007. 1966. 256 pp. $4.95.

THE FIRST BIG STEP: A handbook for parents whose child will soon enter school. National School Public Relations Association, National Education Association, 1201 16th Street NW., Washington, D.C. 20036. 1966. 34 pp. 60 cents.

HOW TO HELP YOUR CHILD IN SCHOOL. Robert Sunley. Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. Public Affairs Pamphlet No. 381. November 1965. 20 pp. 25 cents.

SEX EDUCATION IN THE FAMILY. Francis L. Filas. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1966. 112 pp. $3.95.

MOST OF US ARE MAINLY MOTHERS. Carol Bartholomew. The Macmillan Company, 60 Fifth Avenue, New York, N.Y. 10011. 1966. 203 pp. $4.95.

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

DIALOGUE ON ADOLESCENCE. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 442. 1967. 30 pp. 30 cents.

Presents the highlights of a 1-day meeting on problems facing youth today attended by the 14 members of an ad hoc committee on cooperative planning for youth appointed by the Children's Bureau.

REPORT ON FAMILY PLANNING: activities of the U.S. Department of Health, Education, and Welfare in family planning, fertility, sterility, and population dynamics. Department of Health, Education, and Welfare, Office of the Secretary. September 1966. 35 pp. 25 cents.

The first in a series of annual reports summarizing the family planning activities of the Department.

MENTAL RETARDATION GRANTS: fiscal year 1966. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Individual and Family Services, The Secretary's Committee on Mental Retardation. September 1966. 139 pp. 70 cents.

Lists, by State, the grants awarded in the field of mental retardation—for research and demonstration, training, construction, and others—by the agencies of the Department of Health, Education, and Welfare.

PROS AND CONS: NEW ROLES FOR NONPROFESSIONALS IN CORRECTIONS. Judith G. Benjamin, Marcia K. Freedman, and Edith F. Lynton. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. 1966. 127 pp. 40 cents.

This publication describes some current experiments in the use of nonprofessional personnel, including inmates, in rehabilitative efforts in correctional institutions, and in probation and parole work. It concludes with guidelines for introducing nonprofessionals into agency programs, including suggested career line models.

OBESITY AND HEALTH: a source book of current information for professional health personnel. Department of Health, Education, and Welfare, Public Health Service, Division of Chronic Diseases, Heart Disease Control Program. 1966. 77 pp. 60 cents.

Directed to the health professions, this publication reviews the findings of recent research on obesity, its association with other health problems, and methods of weight reduction.

EDUCATING DISADVANTAGED CHILDREN UNDER SIX; EDUCATING DISADVANTAGED CHILDREN IN THE PRIMARY YEARS; EDUCATING DISADVANTAGED CHILDREN IN THE MIDDLE GRADES; ADMINISTRATION OF SCHOOL PROGRAMS FOR DISADVANTAGED CHILDREN. Helen K. Mackintosh, Lillian Gore, and Gertrude M. Lewis. EDUCATING DISADVANTAGED CHILDREN IN THE ELEMENTARY SCHOOLS: an annotated bibliography. Gertrude M. Lewis and Esther Murow. Department of Health, Education, and Welfare, Office of Education. Disadvantaged Children Series Nos. 1 through 5. 1966. 26 pp., 15 cents; 52 pp., 25 cents; 47 pp., 25 cents; 42 pp., 20 cents; 33 pp., 20 cents, respectively.

A series of reports on techniques and practices in various parts of the country in working with educationally disadvantaged children 3 to 11 years old.

SOCIAL DEVELOPMENT: key to the Great Society. Department of Health, Education, and Welfare, Welfare Administration, Division of Research. WA Publication No. 15. 1966. 92 pp. 55 cents.

Through 55 charts and text, this publication presents data showing an imbalance of social and economic development in the United States. It points out that although the rate of economic growth has been rapid, there have been lags in the development of social welfare programs and services not only for the poor but also for all groups in our population.

LOW-INCOME LIFE STYLES. Lola M. Irelan, editor. Department of Health, Education, and Welfare, Welfare Administration, Division of Research. WA Publication No. 14. 1966. 86 pp. 35 cents.

Five papers summarizing research findings relating to low-income families' general outlook on life, family organization, educational training, health care, and consumer practices.

CHILDREN'S BUREAU ACTIVITIES IN MENTAL RETARDATION. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 14 pp. Single copies free from the Bureau.

Briefly describes the aspects of Children's Bureau programs of health services, child welfare services, and research and demonstration grants that are concerned with mental retardation.

A GUIDE FOR TEACHING POISON PREVENTION IN KINDERGARTENS AND PRIMARY GRADES. Department of Health, Education, and Welfare, Public Health Service, Division of Accident Prevention. PHS Publication No. 1381. Reprinted September 1966. 95 pp. 55 cents.

Offers teachers suggestions for teaching young children ways of safeguarding themselves and the members of their family against accidental poisonings.

DIRECTORY OF PUBLIC TRAINING SCHOOLS SERVING DELINQUENT CHILDREN. Compiled by Kenneth S. Carpenter. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. October 1966. 112 pp. Single copies free from the Bureau.

An eighth revision, this edition lists, by State or jurisdiction, 320 State and local training schools, camps, and reception-diagnostic centers that serve delinquent children committed by the

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courts. Information on each includes capacity, admission ages, average daily population (1965), and the name of the central administrative agency.

THE CONTROL AND TREATMENT OF NARCOTIC USE; THE ALCOHOLIC OFFENDER; and PERSONAL CHARACTERISTICS AND PAROLE OUTCOME. Daniel Glaser and Vincent O'Leary. 1966. 41 pp., 20 cents; 31 pp., 20 cents; and 24 pp., 15 cents, respectively. THE VIOLENT OFFENDER. Daniel Glaser, Donald Kenefick, and Vincent O'Leary. 1966. 39 pp. 20 cents. THE SENTENCING AND PAROLE PROCESS. Daniel Glaser, Fred Cohen, and Vincent O'Leary. 1966. 26 pp. 15 cents. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development.

These five publications were issued for use of the participants of the National Parole Institutes, which are administered by the National Council on Crime and Delinquency, with support from the Office of Juvenile Delinquency and Youth Development.

THE CHILD ABUSE REPORTING LAWS: a tabular view. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 43 pp. 30 cents.

Describes briefly the laws for reporting child abuse in 49 States and the Virgin Islands. Includes information on the age limits of children covered, who should report suspected abuse, nature of injury, to whom to report, legislative directions, immunity, abrogation of evidentiary privileges, availability of central registry, and penalty for failure to report.

VISION AND HEARING SCREENING IN SELECTED CLASSES FOR THE MENTALLY RETARDED—CITY OF DETROIT, MICH. Vision Section and Hearing Conservation Section, Bureau of Maternal and Child Health, Michigan Department of Public Health. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 10 pp. Single copies free from the Bureau.

A report of experiments that demonstrated the effectiveness of standard procedures for testing children's vision and hearing in special classes for mentally retarded children.

TRAINING HEALTH SERVICE WORKERS: the critical challenge. Proceedings of the Conference on Job Development and Training for Workers in Health Services, Washington, D.C., February 14–17, 1966. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Education; and the Department of Labor, Manpower Administration. 1966. 102 pp. 60 cents.

Contains the conference's major presentations and reports of group sessions on programs, practices, and trends in the training and use of auxiliary health service workers and on ways of meeting present and future health manpower needs.

PROGRAMS AND SERVICES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Department of Health, Education, and Welfare, Office of the Secretary. September 1966. 374 pp. $2.

Describes 209 current programs operated under constituent agencies of the Department of Health, Education, and Welfare.

NEIGHBORHOOD LEGAL SERVICES—NEW DIMENSIONS IN THE LAW. Prepared by Jane Handler. Edited by Leora Wood Wells. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. 1966. 79 pp. 35 cents.

A report and analysis of the structures and early experiences of four demonstration projects providing legal services to the poor through improving and extending existing services or developing new ones in coordination with community agencies.

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